EXHIBIT 4

UNITED STATES DISTRICT COURT

FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

PLANNED PARENTHOOD SOUTH)
ATLANTIC, et al.,)
Plaintiffs)
)
vs.)
)
JOSHUA STEIN, et al.,)
Defendants)
)
and)
)
PHILIP E. BERGER, et al.,)
Intervenor-Defendants)

REMOTE DEPOSITION

OF

SUSAN BANE, M.D., PhD.

August 31, 2023 - 2:05 P.M.

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I N D E X

E X A M I N A T I O N S

E X H I B I T S

SUSAN BANE, M.D., PhD, after having been first duly sworn, was examined and testified as follows:

VIDEOTAPE TECHNICIAN: Good afternoon, ladies and gentlemen. We are going on the remote video record on Thursday, August 31, 2023 at 2:05 p.m. I am Carrie Rapaport in association with Discovery Court Reporters in Raleigh, North Carolina. This is a matter pending before the United States District Court for the Middle District of North Carolina in the case captioned Planned Parenthood South Atlantic, et al. versus Joshua Stein, et al. and Philip E. Berger, et al. Case number 1:23-cv-00480-CCE-LPA.

This is the start of media one, volume one of the deposition of Susan Bane, M.D., Ph.D. The deposition is being taken on behalf of the plaintiffs. Starting with the questioning attorney, I will ask counsel to identify yourselves, state who you represent and whether co-counsel or your client are in attendance.

MS. SALVADOR: This is Anjali Salvador with Planned Parenthood Federation of America on behalf of Planned Parenthood South Atlantic. I do have co-counsel with me here today.

MR. BOYLE: Good afternoon. My name is Ellis Boyle, Wake County Bar. I am representing the legislative defendants Berger and Moore and I am joined by Julie Payne with the ADF who is co-counsel.

MS. GRAUNKE: Hi, everyone. I'm Kristi Graunke from the ACLU of North Carolina Legal Foundation, appearing for all plaintiffs. I'm joined today by Elisa Sturkie who is a UNC law student who is externing with us, and also by my co-counsel Brigitte Amiri and Ryan Mendias from ACLU's national office.

MS. SWANSON: Hi. This is Hannah --

MR. WILLIAMS: My name is --

MS. SWANSON: Oh, I'm sorry.

MR. WILLIAMS: Go ahead, Hannah.

MS. SWANSON: Thank you. This is Hannah Swanson also from Planned Parenthood Federation of America for Planned Parenthood South Atlantic.

MR. WILLIAMS: My name is Kevin Williams from the Forsyth County Bar and I represent District Attorney Jim O'Neill.

MS. NARASIMHAN: Good afternoon. My name is Sripiya Narasimhan with the North Carolina Department of Justice representing Attorney General Joshua Stein.

MS. O'BRIEN: Good afternoon. I'm Elizabeth O'Brien also from the North Carolina Department of Justice. I represent the DA defendants other than DA O'Neill and my clients are not present, nor is co-counsel.

MR. BULLERI: I'm Michael Bulleri, also with the North Carolina Department of Justice. I represent the North Carolina Medical Board, North Carolina Board of Nursing.

MS. CROWLEY: Colleen Crowley also with the North Carolina Department of Justice. I represent North Carolina Department of Health and Human Services.

VIDEOTAPE TECHNICIAN: Thank you. As the witness has already been sworn in, you may proceed, Counsel.

BY MS. SALVADOR:

Q. Dr. Bane, good afternoon and thank you for being here today. My name is Anjali Salvador and I'm one of the attorneys representing Planned Parenthood South Atlantic in this case. While we're talking here I might refer to it as PPSAT.

Could you please state your full name for the record?

A. Yes, I'm Susan Bane.

Q. All right. Thank you. We're going to start with some housekeeping and ground rules. Do you understand that you're under oath today the same way that you would be in a court room and that you're obligated to answer my questions truthfully and completely?

A. Yes.

Q. So as you heard, we have a court reporter with us today who will be taking down what we say for a transcript. So please make an effort to continue giving all of your answers verbally like you are instead of nodding or shaking your head. Okay?

A. Yes.

Q. Also, because of the transcript, we're going to need

to do our best not to talk over each other. So please wait for me to finish each question before answering and I'll wait for you to finish before asking my next question. Okay?

A. Yes.

Q. Great. I'll do my very best to ask clear questions. If you don't understand a question, please feel free to let me know and I'll rephrase it or repeat it, whatever you need. But if you do answer I'm going to assume you have understood my question. Okay?

A. That sounds good.

Q. Great. If at any point either in the moment or later in the deposition you realize that you have made a mistake with a prior answer or you want to clarify something, that's totally fine, just let me know. Okay?

A. Okay.

Q. If at any point you need a break, please let me or your attorney know and we'll take one, with the exception that if I'm in the middle of a question you'll have to answer it before we take that break.

Do you understand?

A. I do.

Q. During the deposition your attorney may object to some of my questions. But unless your attorney directly tells you not to answer the question, you still have to answer it.

Do you understand?

A. Yes.

Q. And have you turned off your cell phone like the videographer asked?

A. I have.

Q. Great.

A. Excuse me. Did you say turn off it or -- I muted it.

Q. It would be great if you could either -- definitely silence it, but turning it off would be preferable just so we know you're not looking at it during the deposition.

A. Okay. So I just have it turned over on its backside, plus it's muted.

Q. That's fine. So this is a little invasive and I apologize, but it's a standard question at the start of depositions. Are you dealing with any illness or taking any substance that would affect your memory or prevent you from being able to understand and answer my questions today?

A. No.

Q. Thanks. Have you ever had your deposition taken before?

A. I have.

Q. How many times?

A. As in expert witness?

Q. Both as an expert witness or as a fact witness, if that's happened.

A. So I was an expert in a medical malpractice case and

then I have a son with special needs and I was an expert in a case related to him.

Q. Did either of those --

A. Sorry, I wasn't an expert. I was his mom.

Q. Understood. Did either of those cases relate to abortion in any way?

A. They did not.

Q. Other than the report you submitted in this case, have you submitted a -- I'm sorry, the declaration -- have you submitted a declaration in a legal case before?

A. I have not.

Q. Have you testified in any court before?

A. Yes, in the case that I was the expert witness, the malpractice case.

Q. Got it. What -- so you said you were an expert in that case, correct?

A. Correct.

Q. So you were not a party in that case?

A. No, I was not.

Q. Have you testified before any legislative body?

A. Yes.

Q. Can you describe that testimony, please?

A. Sure. I have testified three times at the North Carolina State Legislation. One was on the Bill SB20. One was on a conscience right, conscience protection bill, and the

other was on the bill related to gender affirmation care in minors.

Q. Got it.

MS. SALVADOR: Counsel, at the break could we get copies of that testimony, please?

MR. BOYLE: Are you asking me?

MS. SALVADOR: Yes. I think we had asked you to produce Dr. Bane's testimony as one of our requests for production.

MR. BOYLE: I don't think she has it.

MS. SALVADOR: Okay.

BY MS. SALVADOR:

Q. Dr. Bane, was that verbal testimony?

A. Yes.

Q. Okay. Could you describe the nature of your testimony on SB20, please?

A. Yes. I was one of -- I believe they had 10 individuals have -- I think we had one-and-a-half -- one or two minutes and it was -- so it was the public who could testify. I think they had 10 of us who supported the bill and 10 who did not. And so I spoke as a citizen of North Carolina and a medical doctor, an ob-gyn, why I supported the bill.

Q. Why did you support the bill, according to your testimony?

A. I supported the bill because as a medical doctor I

don't believe the direct and intentional killing of another human being is part of medical practice and that for 50 years we have basically had unfettered access to abortion in the United States and it has not impacted maternal mortality, that women in North Carolina need solutions, not greater access. And that we need to look at root causes. And that this bill has provisions to support women who are in that position of an unplanned pregnancy and have socioeconomic, typically, factors are the main ones that both the literature and I see in my practice as the reasons and there are provisions in the bill to support them.

Q. Thank you for that description. You mentioned that you also testified on a bill relating to I believe you said freedom of conscience, is that correct?

A. I did.

Q. Could you please describe your testimony for that bill?

MR. BOYLE: Objection. I want to put on the record that there's been a lot of comment from the plaintiff's side about focusing this case on -- at this stage of discovery on the preliminary injunction hearing and I don't know if she may be talking about something that's germane to that.

MS. SALVADOR: That's a speaking objection and speaking objections aren't allowed under the rules. So your objection is noted.

BY MS. SALVADOR:

Q. Dr. Bane, if you could please answer.

A. Sure. So I don't have in my head what I said as fresh, but I spoke basically about the fact that conscience rights, so what is ethically and morally allowed -- that we have a right both as healthcare practitioners of all sorts to be able to recognize our conscience and not have to do things that go against our conscience. I would say that's the gist of what I talked about.

Q. And you said the third bill was related to gender, is that correct?

A. Yes.

Q. Was there anything in your testimony related to abortion for that bill?

A. No.

Q. Got it. Thank you. Do you have any notes or files related to this case with you right now either in front of you in hard copy or open digitally?

A. I don't have anything open digitally that I can see. If you ask me to go to something I have digital copies of things. I have my clean copy of my declaration here and then I have -- sometimes when I listen I like to take notes, so I have this pad which I put all your names when you introduced yourselves, but it's empty otherwise.

Q. Understood. Thank you.

A. And then over -- way over -- I'm in a hotel room, a desk, I have all the copies of -- in my declaration of the references I used. Actually I probably have the majority of them. Some were digital and too long.

Q. Got it. Thank you. So when were you first contacted about participating as an expert witness in this case?

A. I think it was about a month ago.

Q. And who specifically have you communicated with regarding this case?

A. Julia Payne with ADF reached out to me and then -- and I have talked to Ellis about it. The other person is Dr. John Thorpe who's at Chapel Hill. He is a colleague and friend of mine and was -- I think and potentially be involved and then they decided I would do it.

Q. What did you speak to Dr. Thorpe about?

A. He is experienced regarding -- he's done a lot of depositions. So I actually asked him because I had never done one with the law, what to expect with the deposition.

Q. Did he contribute any sources for you to use in your declaration?

A. He did not.

Q. Did he give you advice on what would go into your declaration?

A. No. We talked about the logistics of the deposition itself.

Q. And you mentioned that you thought he was originally going to be involved in this case. How do you know that?

A. When Julia reached out to individuals to potentially be in the case, he was one of the people on the email.

Q. Do you know why you rather than he are an expert in this case?

MR. BOYLE: I'm going to object and I'm going to instruct you not to answer that. That would be work product. That's protected.

BY MS. SALVADOR:

Q. Other than the folks you have already named, have you communicated with anyone else regarding this case?

A. No.

Q. What topics are you providing your opinion on in this case?

A. Can I go back to the last question? I have family -- my family knows I'm in the case. I'm a very literal thinker so when you said have you talked with anyone, of course some of my family and colleagues know about it, but not the specifics of my declaration.

Q. So they know that you're in a deposition right now, but do they know what you're talking about?

A. They know it's about SB20.

Q. Okay. But did you discuss the specific contents of your declaration with them?

A. No.

Q. So what topics are you providing your opinion on in this case?

A. I'm providing my opinion on the hospitalization requirement and the documentation of an intrauterine pregnancy prior to chemical or medication abortion.

Q. Are you being paid for your participation in this case?

A. Yes.

Q. How much are you being paid for your participation in this case?

A. $500 per hour.

Q. And about how many hours have you spent working on this case so far?

A. A lot. I can't quantify -- I don't have -- I mean, I have it written down elsewhere, but I haven't tallied it. But a month ago I was asked and I know towards the end of July I started working on a declaration and the declaration itself took several hours so...

Q. Would you say that since you were contacted you have spent several hours a week on this case?

A. Yes.

Q. Would you say you have spent more than 10 hours a week on this case?

A. Yes.

Q. Got it. Thank you. How did you prepare for today's deposition?

MR. BOYLE: I'll just instruct you not to discuss anything specifically that you said with your lawyer, but you can answer generally.

THE WITNESS: Sure. It was -- sorry. And I'm sorry -- is it -- how do I pronounce your name?

BY MS. SALVADOR:

Q. Sure. It's Anjali.

A. Anjali. And you asked me specifically for today?

Q. No. How did you prepare generally for today's deposition, without revealing the contents of any conversation you had with your attorneys?

A. Sure. So really reviewing my declaration was the biggest thing and then reviewing the responses from the other individuals who are witnesses. They have declarations too.

Q. Other than your attorneys, did you speak with anyone about the substance of the deposition testimony you'll give today?

A. I did not.

Q. You mentioned reviewing your own declaration and the other declarations in this case. Did you review any other documents to prepare for this deposition?

A. So I -- the resources that I used and then some of the other literature in this area I reviewed.

Q. When you say some of the other literature in this area, what do you mean by that?

A. Literature related to complications related to pregnancy. I think all the ACOG guidelines I used are part of my references, so they are above and -- I mean, I already said I included those. I did get information about Planned Parenthood South Atlantic and their policies, as well as some of the other information they provided. For example, numbers that they -- of abortions they do in their centers and things like that.

Q. Thanks. Other than speaking with your attorneys and reviewing the documents you mentioned, did you do anything else to prepare for today's deposition?

A. I prayed.

Q. So you have -- you have already mentioned that you prepared an expert declaration in this case, right?

A. I have.

Q. Okay.

MS. SALVADOR: So I am going to drop it into the chat so that every one can access it. It's already been premarked as an exhibit. I believe it is Exhibit-P.

- - -

(Document marked as Exhibit-P for identification.)

- - -

BY MS. SALVADOR:

Q. So Dr. Bane, is this an accurate copy of the -- well, first I should say, are you able to open the document that I dropped into the chat?

A. Let me try because I have my own copy, so I wasn't looking to do that. It's wanting me to save it first, so just a sec.

Q. Sure.

(Pause.)

A. Yes, I have it now.

Q. And is this an accurate copy of the expert declaration you submitted in this case?

A. Give me a minute.

Q. Sure.

(Pause.)

A. Yes, it's what I submitted.

Q. Thank you. And if it's easier, for your purposes, to refer to your paper copy rather than the digital copy, that's fine. We just needed to make sure that everyone on this deposition is looking at the same document.

A. Okay.

Q. Please describe the process of drafting this declaration.

A. So really understanding what specifically I was being asked to address was the first thing, which was the two things

I already mentioned regarding the IUP documentation requirement and hospital requirement and reviewing the literature related to that, including the maternal mortality report for North Carolina that I thought was an important document related to this.

Q. And did you write all of this declaration yourself?

A. One hundred percent.

Q. Have you read all of the documents cited in your declaration in their entirety?

A. Yes.

Q. Other than your attorneys, did you work with anyone to prepare your declaration?

A. No.

Q. Have you discussed the contents of your declaration with anyone other than your attorneys?

A. No.

Q. Did you read the declarations that Dr. Farris submitted in this case in their entirety?

A. Yes.

Q. Did you read the sources cited in Dr. Farris's declarations?

A. I looked at them, but I can't say that I read all of them.

Q. Got it. Thank you. And did you read the declarations that Dr. Borass submitted in this case in their entirety?

A. Yes. And I'll add that I had those when I was writing my declaration, so I should have included them as part of my answer regarding how I prepared this.

Q. Got it. Thank you. And did you read the sources cited in Dr. Borass's declarations?

A. I looked at them and -- so I can't say I read them from front to back.

Q. So I'd like to turn now to your C.V., which is Exhibit-A, attached to your declaration which we have already pulled up and you have in front of you.

So is this C.V. current?

A. It's very current. It's not current as of today. I have done two talks this week at a conference that aren't on there, things like that.

Q. Got it. Thank you. And you graduated from -- with a Bachelor of Science degree from Atlantic Christian College in 1987, correct?

A. Correct.

Q. And now it's called Barton College, is that right?

A. Correct.

Q. So we'll get to the specifics of your career in a bit, but am I correct that you also ended up working at Barton College for a number of years?

A. Yes.

Q. After you attended Barton College, you graduated from

the University of Illinois with a Master of Science in kinesiology in 1989, is that right?

A. Yes.

Q. And then you received a Ph.D. in kinesiology from the University of Illinois in 1995, is that right?

A. Correct.

Q. And you also got an M.D. from the same place in 1997, is that right?

A. Correct.

Q. Did those two programs overlap?

A. So they are -- it was a 10-year program from the standpoint of I went there in 1987 and I finished in 1997. So from '87 to '89 I did my master's degree and then I was in a M.D. Ph.D. medical scholars program. So I had a total of six years of graduate work with my master's and my Ph.D. and four years of medical school.

Q. Got it. Thank you. And you completed your residency in obstetrics and gynecology at the East Carolina University School of Medicine, right?

A. Right.

Q. And you completed that in 2001?

A. Yes.

Q. Are there any other educational credentials you have that are not on your C.V.?

A. Not that are graduate level degrees and a master

level. I have certifications, but I think they're all on my C.V.

Q. Okay. Thanks. So after you completed your residency, did you work as an ob-gyn?

A. I did. I was in private practice at Greenville Obstetrics and Gynecology in Greenville, North Carolina for nine years.

Q. And what were your duties at Greenville?

A. So in my practice -- it was a private practice, obstetrics and gynecology. We were part of a bigger group called Physicians East, which was a multispecialty group. So I did obstetrical care and gynecological care both in the office and in the hospital taking call. I had medical students and residents from the Brody School of Medicine at East Carolina that were with me. I also had students from UNC Chapel Hill who rotated with me.

Q. And in your declaration you state that you helped women deliver over 1,000 babies and supervised midwives who helped women deliver several thousand babies, is that right?

A. Correct.

Q. Did all of those deliveries take place in hospitals?

A. Yes.

Q. What is your familiarity, if any, with midwives in North Carolina delivering babies outside of hospitals?

A. I'm not familiar.

Q. And you mentioned your gynecological practice included gynecological surgery, is that right?

A. Yes.

Q. What type of gynecological surgery did you perform?

A. I performed D&Cs for miscarriage. I performed vaginal and abdominal hysterectomies. I performed urogynecological surgery. That was more limited. And I'm talking about basically in the hospital. If a woman had an ectopic pregnancy I would do laparoscopy for removing cysts, things like that.

Q. And just to clarify, you used a word -- did you say urogynecological?

A. Sorry, uro. U-r-o. So it's bladder issues.

Q. Got it. Thank you. And did you ever perform any of those procedures outside of the hospital?

A. Those procedures, no.

Q. Which of the procedures you mentioned, if any, did you perform outside of the hospital?

A. None of those procedures outside of the hospital.

Q. So you never --

A. So -- excuse me. We did have as part of our hospital a surgical center. So it would be like a same-day surgery center. So I don't know if you're calling that -- that was freestanding outpatient surgical center. So I didn't think of that as a hospital. But I did not provide any of those surgeries I mentioned in my outpatient clinic.

Q. Got it. Thank you. So you mentioned miscarriage D&Cs as one of the procedures you performed, is that right?

A. Correct.

Q. What are the risks of miscarriage D&Cs?

A. So the risks are -- the biggest one acutely is hemorrhage and infection. You can also have a uterine perforation and that can lead to damage of adjacent organs around the uterus, which are primarily bowel and bladder. And you can also have death.

Q. Thank you for that. And we'll go into all of those a little bit more later, but just kind of continuing with the description of your work at Greenville. In your work at Greenville did you ever prescribe contraception?

A. Yes.

Q. What types of contraception?

A. Hormonal and non-hormonal. So hormonal included birth control pills or patch, Depo-Provera, which is an injection shot, IUDs, tubal ligations, which are actually surgeries. I would say those are the main things.

Q. And in your work at Greenville did you ever perform abortions?

A. I did not perform induced abortions, which I'm using that as the CDC's definition of an induced abortion.

Q. What is that definition?

A. So it's an intervention that is designed to -- whether

it's a suspected or a documented pregnancy, to not result in a live birth.

Q. And so you referred to induced abortions as though they were one type of abortion, is that right?

A. Correct.

Q. What are the other types of abortion?

A. So abortion is a term -- it's an umbrella term in medicine and induced abortion is one type. We have what's called a spontaneous abortion, commonly known as a miscarriage. A threatened abortion would be when somebody comes into our office, maybe they're cramping or bleeding and we do an ultrasound and everything looks fine but they're possibly going to miscarry. There's incomplete abortions, which would be a woman who's in the middle of miscarrying. A complete abortion is typically she's already miscarried. So those are examples of terminology.

Q. So you described your practice as involving treatment of spontaneous abortions, by your definition, is that correct?

A. Yes.

Q. And colloquially is that referred to as miscarriage management?

A. Yes.

Q. So did miscarriage management ever involve providing patients with medication?

A. We could give that as an option, but it was primarily

expectant management, meaning if she was bleeding and didn't want to have a D&C, we had confirmed that she did not have a viable pregnancy. But often times we would do surgery or we would do expectant management.

Q. And that expectant management would sometimes involve providing the patient with medication, is that right?

A. No. I'm sorry. Them on their own doing it. So you can do medication management also.

Q. Okay.

A. We can do that. We just didn't have many people that wanted that option.

Q. Got it. But did you ever provide medication management?

A. Yes.

Q. Did that medication include Mifepistone and Misoprostol?

A. Just Misoprostol.

Q. Got it. Thank you. Did you ever provide Misoprostol to a patient outside of a hospital setting?

A. So if -- I can't recall a specific patient, but in terms of being able to -- if she had a miscarriage and hadn't passed it and wanted to have medical management, that was an option she was given.

Q. And that was an option that she would be given in an outpatient facility, is that right?

A. Yes.

Q. Did you consider providing Misoprostol to a patient in an outpatient facility to be safe?

A. Sorry, I heard a ding from somebody. Could you say it again? Did I consider it to be safe like doing that?

Q. Yes. That's right.

A. Yeah. So if it was clinically indicated, I'm going to do things that I think are safe and that the patient and I align with in terms of her, you know, shared decisionmaking in the process.

Q. And that would sometimes include providing Misoprostol to a patient in an outpatient clinic as part of miscarriage management, is that right?

A. Yes.

Q. To your knowledge did you ever provide Misoprostol to a patient where there was fetal cardiac activity still present?

A. No.

Q. Did your miscarriage management involve providing aspiration procedures?

A. If you're calling an aspiration procedure a D&C, yes, and that would have been at the hospital.

Q. Could you define a D&C, please?

A. So dilatation and curettage. But it -- in the past that was equated with sharp curettage where you would scrape the lining. And we know that that's associated with something

called Asherman's syndrome, which is adhesions. And so now I think the term is still used but it's usually with suction aspiration. But we still use the term D&C often.

Q. Have you ever performed a D&C, to your knowledge, where there was fetal cardiac activity present?

A. No.

Q. Did your miscarriage management involve any dilatation and evacuation procedures or D&Es?

A. No.

Q. Just one second, I'm going back and forth in my document just to make sure I didn't miss any questions. So you mentioned -- we were talking about your work at Greenville and your resume lists your work at Greenville and East Carolina University separately, but you kind of described them as together. So could you clarify that relationship, please?

A. Sure. So I was not an employee of East Carolina University. We were clinical facility members if we taught residents and had medical students on there. So I was employed a hundred percent by Greenville Ob-Gyn and part of Physicians East and I volunteered because I love to educate and had students with me. I also taught some lectures -- not regularly, but I did teach a two-week fourth year elective called Residency 101 and that was volunteer service work also.

Q. Go it. So in our discussion of your practice so far, is there anything different about your East Carolina practice

versus your Greenville practice?

A. I don't consider that I ever had an East Carolina practice. If it comes across as that in my C.V. I should change it. But no, I was never employed as -- I guess when I was a resident they paid me, but once I graduated from residency I was at Greenville Ob-Gyn.

Q. Got it. And in your teaching, did you ever teach your students about abortion?

A. No. I mean, I did do lectures on that, I guess I would say.

Q. Understood. So we have generally been talking about your ob-gyn practice from 2001 to 2010, is that correct?

A. Yes.

Q. Okay. And is there any part of that ob-gyn work -- or, I'm sorry. Have we discussed basically everything you did in your ob-gyn work?

A. No.

Q. So what else did you do as part of that ob-gyn work?

A. So I took call. I delivered babies. I did vaginally and vacuum-assisted. I did c-sections and the full gamut of what an obstetrician who is covering a hospital would do. Consults all across the hospital. In my practice a big part of my gyn practice was yearly physicals with women. And I did prenatal care.

Q. And in your medical practice, have you ever prescribed

medication off label?

A. Yes.

Q. In what circumstances?

A. When women are menopausal and having hot flashes, for example, SSRIs, which are antidepressants, have been shown to help with hot flashes, for example. So I may prescribe one of those.

Q. Did you consider that safe?

A. Yeah. Yes, I did.

Q. Why did you consider that to be safe?

A. I think that there were several studies that showed that it was effective. The potential side effects of prescribing it were minimal. It was well studied in women -- it is a drug that has been well studied and so it's been commonly used. Like, for example, Prozac, let's say, was one of them that we would use. So I felt comfortable that there was not a harm that I was causing. And I also knew that if she didn't like it, we could stop it.

Q. Got it. Thank you. And we have already discussed Misoprostol. Have you ever prescribed Mifepistone or Mifeprex to a patient?

A. I have not.

Q. Have you ever provided an abortion?

A. I have never performed an induced abortion, no.

Q. You state in your declaration that while you were in

private practice you cared for preborn children with life-limiting conditions, is that correct?

A. Yes.

Q. Could you describe what you mean by that?

A. So they are -- typically -- I mean, so a fetus is after eight weeks. So usually the diagnoses aren't made when they're embryos. And so they have a diagnoses that we know that if the normal age limit for men and women is in the 70s and 80s, that they have a condition that has been diagnosed that the likelihood of them surviving to 70 or 80 is not expected. So that would be a life-limiting condition.

Q. And how did you treat -- how did you treat your patients in that situation?

A. A lot of love. It was hard because they -- you know, it's a tragedy when you expect to have a healthy child and you're told that. So we would refer them to maternal-fetal medicine because maternal-fetal medicine works with high-risk pregnancies. And then depending on the situation they may come back to our practice and we provide their prenatal care or there may be a transfer of care.

Q. And a transfer of care for what?

A. Well, usually for the maternal-fetal medicine specialist to take over the care of them, whether it's -- there was going to be a delivery or if the patient had decided that they wanted to have an induced abortion, they would provide

that.

Q. And would you ever refer those patients directly for an induced abortion?

A. No.

Q. Have you ever performed a previability induction on a pregnant patient?

A. Can you define previability?

Q. Sure. How would you define viability?

A. Well, traditionally it is able to survive outside the mother. And that's changed over time of course because our understanding of how to care for premature babies is better. So I assume you're asking babies that -- maybe I shouldn't assume -- but that are too young to survive if they were born at the time of the induction.

Q. That's right. Have you ever performed an induction on a pregnant patient at the stage where their fetus was not developed enough to survive outside the womb?

A. Yes, I have.

Q. About how many times?

A. Lots and lots. Residency in four years because we were a Level 1 hospital where we had a lot of transfers that came in -- excuse me. I'm sorry. I have a reminder coming up that was loud. We had a lot of patients transferred to us that had, for example, preterm premature rupture of membranes. And -- or other things that caused us to have to do a premature

separation of the maternal and fetal patient. So that was four years and then I had nine years in private practice. So, you know, greater than a hundred.

Q. Got it. Thank you. And did you consider those inductions to be abortions?

A. No, not induced abortions.

Q. So you referred to preterm premature rupture of membranes or pprom. What other conditions would lead you to perform an induction in these circumstances?

A. That would probably be the most common. Really it would be situations in which typically the mom is so sick that if we do not do an induction and separate our maternal and fetal patient, both patients would die. So, you know, it would be any indication that the mom was so sick. And occasionally it's a fetal indication, but it's usually the mother.

Q. Did you ever recommend to one of your patients that they have an induction before the fetus could survive outside the woman?

A. Yeah, I had a lot of hard conversations about that.

Q. Would you have recommended an induction to, for example, a patient with gestational diabetes at risk of going blind?

A. I would need more clinical context than a hypothetical like that.

Q. Would you wait until the patient was dying before you

recommended such an induction?

MR. BOYLE: Objection. You can answer.

THE WITNESS: Did you say you can answer?

MR. BOYLE: Yes, you can answer.

THE WITNESS: Okay. Would you repeat the question, please.

BY MS. SALVADOR:

Q. Sure. Would you wait until the patient -- would you recommend waiting until the patient -- sorry. Let me start over. Would you wait until the patient was dying to recommend such an induction?

MR. BOYLE: Objection. You can answer.

THE WITNESS: So I just want to kind of pull back for a second and clarify. So an induced abortion has the intention of not having a live birth. So when I would recommend an induction in these cases, my intention was hopefully to have a live mom for sure and a live baby. And so there were times, for example, if she's what's called periviable, she's near where maybe the baby did have a fighting chance and her risks are small at that point that we could do expectant management. So, for example, with pprom, one of the -- ACOG'S, you know, practice bulletin on pprom says expectant management. And so I'm trained to be able to watch for signs of infection in the mom and daily, you know, go see her and multiple times a day do vital signs and at the very beginning

of the process say to her, you know -- let's say she's 22 weeks is we have a couple different options here and one of them is to go ahead and deliver you. And -- well, there are 22 weekers that have survived. So let me say 20 weeks. And say to her that we can wait. We can do expectant management and if we do that we're going to have to monitor you very closely and if there's a sign that you have what's called chorioamnionitis I'm going to recommend induction.

Q. And you said -- please repeat that term, chorioamnionitis?

A. Chorioamnionitis. So it's an infection of the amniotic fluid.

Q. Would you recommend -- would you ever recommend to a patient waiting until sepsis develops to have an induction?

A. Heck, no.

Q. Between when you finished residency in 2010, did you work as an ob-gyn anywhere other than Greenville and then its associated work at East Carolina University?

A. No.

Q. After you stopped working at Greenville, where did you work next?

A. So I worked at Barton College, which was Atlantic Christian when I was there, and I have been there since 2010 -- well, I was an adjunct, but full time starting in 2011, until this summer and I'm no longer there.

Q. Could you generally describe your role at Barton, please?

A. Sure. I was initially hired as an associate professor of Allied Health and Sports Studies, although I think our department had a different name back then. But I was an associate professor. So my Ph.D. is in kinesiology, which is exercise science. And so I taught classes ranging from anatomy and physiology to exercise physiology, exercise psychology. After I believe my first year I was asked to run the honors program. So I taught in the honors program and had an administrative role there and continued to teach, but as time went on I taught less and had more administrative responsibilities, including dean of graduate and professional studies. And then the last few years I have been the director of a partnership with Area L AHEC, at Barton College.

Q. I'm sorry, what is that term, Area L AHEC?

A. AHEC. So AHEC is a system within -- actually, it's a national organization, but each state -- I believe most of the states have AHECs. And they work on workforce development, retention and diversity. And so we ran a program on campus with college students trying to increase health careers awareness, but also diversity within the healthcare system.

Q. And did your work at Barton also involve practicing as a women's health physician at Lee Student Health Center?

A. Yes, it did. I was in there a few half days a week

when I first started. I think it was the first couple years. But then as my administrative duties increased I wasn't able to do direct patient care in there and I served more on a consultative role.

Q. Did you prescribe contraception to your patients at Lee Student Health Center?

A. Yes.

Q. Did you ever talk to any of them -- I'm sorry. Were any students you treated at Lee Student Health Center pregnant?

A. Yes.

Q. Would your treatment of students ever involve talking to them about abortion?

A. Yes.

Q. Describe those conversations about abortion, please.

A. Yeah. So I basically want women to be empowered with information before they make a decision of such massive consequence. And so it would really be helping them understand their legal choices in the State of North Carolina. Some of our students are from out of state. And so helping them understand they had the option to give birth, to give birth and parent, to give birth and place the child for adoption, or to give permission to a healthcare practitioner to do an abortion. We have a lot of student athletes at our campus. Probably close to 70 percent of our students are athletes, so there was always conversation typically about how it would impact their

play and scholarships and things like that. So I really just wanted them to be really well informed before they made a decision.

Q. Did any of the students who you spoke with about their decision ever express to you a desire to have an abortion?

A. Yes.

Q. And would you support them in that decision?

A. You would have to define support them.

Q. Sure. Would you ever affirm their decision to have an abortion?

MR. BOYLE: Objection. Object to form. You can answer.

THE WITNESS: So what I would talk to them about are -- well, risks -- I would not refer them for an abortion because for me the direct and intentional killing of another human being is not part of healthcare and so I didn't want to contribute to harming one of my patients because I have -- when she's in front of me, I have two patients in front of me. So I wouldn't refer them. What I would do is help them understand the risks, benefits and alternatives.

BY MS. SALVADOR:

Q. And -- I'm sorry, I didn't mean to interrupt you.

A. It's okay.

Q. So you said risks, benefits and alternatives. What would the benefits be?

A. Of which choice?

Q. Of an abortion.

A. Oh, risk, benefit. Basically that nobody would have to know they're pregnant typically and that they would likely be able to compete in their sport.

Q. Why did you leave Barton?

A. I left Barton -- probably should have left two years ago because I really felt like God was calling me to work more with women with unplanned pregnancy. I have been a volunteer for years at Pregnancy Centers and often times when you're a volunteer medical director you are reading all the ultrasounds. But we had -- we needed -- we didn't have a nurse and we had trouble finding one a few years back and I said well, I can do ultrasound. I will go in there and do it. And I just love working with these women. Every woman now has an unplanned pregnancy and I just have a heart for women. And I want them to be able to -- I want to be able to address the barriers for why women feel like the best choice in front of them is ending the life of their own child. I think that it's sad that we have the best of our legal and medical minds in our country and that's the best we can offer for women for equality is to end the life of their children and I just think that's wrong. So I wanted to work full time caring for women in these situations and there wasn't time to do my job at Barton and that.

Q. Understood. Thank you. So before we get to your

Pregnancy Center work I want to talk a little bit about your professional associations.

A. Okay.

Q. Are you currently a member of the American College of Obstetricians and Gynecologists?

A. I am currently not.

Q. Okay. And we'll call that ACOG, is that okay?

A. Yes.

Q. Were you ever a member of ACOG?

A. Yeah, for a long time.

Q. And do you remember what years?

A. I believe when I first started private practice, 2001. I might have been a member during residency, but I'm not a hundred percent sure of that. Because if so, I think they would have paid for a membership. And so I started in 2001 and I stopped my membership a year or two ago.

Q. Got it. I think your C.V. says 1997 and 2021. Does that sound right?

A. It does.

Q. So why are you no longer a member of ACOG?

A. So I have got -- I think ACOG does great work, but I really philosophically disagree in the abortion area with induced abortion. And I feel like it was an organization that did not represent so many of us who really feel like the direct and intentional killing of our fetal patient, there's no

purpose in medicine for that. And I -- ACOG has I think it's eight percent of our dues that go towards advocacy work. I will say they do some great advocacy work, but I couldn't -- they wouldn't allow us to not contribute that part. And so I just in good faith, I didn't want to know that some of my dues were going to advocate for induced abortion.

Q. Did anyone suggest to you that you end your ACOG membership?

A. No.

Q. ACOG members aren't required to hold any particular view of abortion as a precondition of membership, are they?

A. No.

Q. And ACOG'S membership includes individuals who are opposed to abortion, is that right?

MR. BOYLE: Objection.

THE WITNESS: I know lots of colleagues that are members of ACOG that are pro-life and pro-choice, so I -- there are members of both in ACOG.

BY MS. SALVADOR:

Q. And you cite ACOG bulletins on early pregnancy loss and tubal ectopic pregnancy in your declaration, is that right?

A. Do.

Q. And you also cite an ACOG committee opinion on methods of estimating pregnancy due date, is that right?

A. Yes.

Q. So you believe that ACOG is a reliable source of information?

A. So, as I said when you asked me the question about why I left, ACOG does a lot of great work. I just disagree that they -- their position on abortion access, their abortion policy. And so there's a part of ACOG that I don't agree with and for a while I considered leaving and it was just in the last few years I felt like -- particularly when they wouldn't allow me to not contribute to their advocacy work.

MR. BOYLE: I just ask -- we have been going for about an hour. When you get a chance, can we take a break, please?

MS. SALVADOR: Sure. We have just got one or two more questions on ACOG and then we can break after that, if that works.

BY MS. SALVADOR:

Q. So would you find ACOG bulletins on abortion to be reliable?

A. Well, I disagree with them and so it is -- a lot of it is ACOG'S opinion, without even caring that so many of us, the majority of -- based on studies that have been cited, you know, don't do induced abortions. So they advocate for laws that I don't agree with. And so --

Q. But is it your position that the medical information in ACOG'S bulletins on abortion is unreliable?

A. I don't think I can answer that without looking at them. Like what medical information you're asking me to answer about.

Q. Okay. Understood.

MS. SALVADOR: We can take a break now. Would 10 minutes work?

THE WITNESS: Sure.

MS. SALVADOR: Okay. Why don't we go off the record.

VIDEOTAPE TECHNICIAN: Thank you. We are now going off the video record. The time is 3:07 p.m.

(A break was taken.)

VIDEOTAPE TECHNICIAN: We are now back on the video record. The time is 3:17 p.m.

BY MS. SALVADOR:

Q. Thank you, Dr. Bane. So before we go back to your professional associations, I wanted to ask you whether John Thorpe reviewed a draft of your declaration?

A. No, he did not.

Q. Okay. Thank you. So going back to your professional associations, you're a member of the American Association of Pro-Life Obstetricians and Gynecologists, is that correct?

A. Yes.

Q. And I'll refer to that as AAPLOG, if that's all right?

A. Yes.

Q. How long have you been a member of AAPLOG?

A. I think two years maybe.

Q. You currently serve on their board, is that right?

A. I do.

Q. Do you have a title other than board member?

A. I just got a title. I am the team leader for education advocacy. The CEO, Donna Harrison, stepped down as the CEO and Dr. Christina Francis became the CEO. So I took her place.

Q. So you took her place as CEO?

A. No. No. No. Sorry. As the team leader on the board for education and advocacy.

Q. Understood. So what does your role as team leader for education and advocacy entail?

A. Well, it's brand new so my understanding -- I haven't really had a board meeting in which I have lead it yet, but it's really going to be related to both patient and practitioner educational material that looks at the medical evidence and advocacy work in terms of really equipping practitioners who have a pro-life perspective to be able to communicate their -- why they have that perspective.

Q. Would it be fair to say that communicating their perspective is advocacy?

A. Yes.

Q. Do you consider yourself a pro-life advocate?

A. I stand up for pro-life values. I stand up for both my maternal and my fetal patients. So that would be my definition of being an advocate for them. I also stand up for medical students and residents and healthcare practitioners of all types who acknowledge and want to have health and wholeness for both their maternal and fetal patients.

Q. So you said you were new to this -- I'm sorry, I forget exactly what it's called, but the education and advocacy --

A. Team leader.

Q. -- team leader role. But you have been on the board of AAPLOG for sometime, is that correct?

A. For a year.

Q. What do your duties entail as a board member?

A. So -- what do my duties entail? So in terms of oversight -- things that I have had to do. So I have attended one face-to-face meeting and two virtual meetings. So basically going over the strategic plan, which was already made when I was there, but reviewing that. Updating the strategic plan. So more a visionary picture for the organization. Fiscal responsibility. We are a nonprofit and we do not have a lobbying arm to what we do in terms of -- I think it's called a C4 maybe. I don't know that for sure. So making sure that we are educating, but not lobbying. So, so far I would say big decisions that are strategic are what our role is in our

governance.

Q. What's your understanding of AAPLOG's position on abortion?

A. You said AAPLOG, right?

Q. Yes.

A. That induced abortion as defined earlier, that it -- it is not healthcare and it is not -- the direct intentional killing of one of our patients we should never do.

Q. Have you attended any expert witness trainings conducted by AAPLOG?

A. Yes, I did attend one.

Q. Could you generally describe what that training entailed?

A. Yes. A communications -- it was one day -- I think it was one day. It might have been -- no, it was one day. A communications expert spent the morning just kind of talking to us regarding interviews with reporters and kind of what that world is like. And then the other half of the day was more about being an expert witness as I'm being now.

Q. And what training or do you remember what the training covered on being an expert witness like you're doing right now?

A. So they had some lawyers that came and just kind of talked about depositions and we did a -- each of us did an individual short mock deposition. We ran out of time, to be honest, so I didn't really do much with that part.

Q. Well, now you're getting the real thing.

A. Amen.

Q. And you were a committee member of the Preborn to End of Life Advisory Committee for the Diocese of Raleigh from 2013 to 2020, is that correct?

A. I was a member and we had one meeting during that time.

Q. Got it. So it sounds like not much. But what did your duties as a committee member entail?

A. Basically if the diocese needed direction on life issues, then they would come to us.

Q. Did you do any work relating to abortion as part of that committee?

A. Well, the one meeting we had, which was my first and only time going to Raleigh for it, I honestly can't remember the content. I do know the woman who is in charge of their Right to Life program was there, but I don't recall that it was specific to abortion.

Q. Got it. Thank you. Have you ever had a complaint made against you by a patient?

A. Yes.

Q. Could you describe that, please?

A. I had a patient that she was in our practice. She had twins. I had not met her until I was on call and she came in and -- when I took over call she was in labor and her twins

were vertex. Vertex. So you can do a vaginal delivery. And the first baby was delivered and he did fine, but as soon as he was delivered the second baby had a big deceleration, which I was worried about. But then that baby recovered. And I had -- so I had taken off the fetal heart rate monitors because I was using ultrasound to make sure the second baby didn't change positions. And so I manually palpated her abdomen. I was looking at the heart rate monitor and everything and that baby was born and he was very flaccid and had to be resuscitated and he died four days later. And looking back at it I did not recognize that that baby was having a hard time. I thought it was what are called early decelerations. But looking closely at it they were called late decelerations. And so I should have done an emergency c-section.

Q. And what was the resolution of that complaint?

A. Am I allowed to share -- I thought that was -- I mean, I'm happy to say we settled, but I don't know if I'm allowed to share more than that. The hospital settled and then my practice settled.

Q. Got it. And have you ever had a complaint made against you by a student?

A. By a student? Well, they do evaluations at the end of the year and not all of them are, you know -- you know, some students don't like me, but not from the context of what you're talking about medically. So I'll have to say no, other than

what I have already said.

Q. Understood. Thank you.

A. Yeah.

Q. Have you ever had a complaint made against you, an official complaint made against you by a colleague?

A. So I would say -- so an official complaint like with human resources?

Q. Sure.

A. No.

Q. Have you ever had a -- what sort of, if any, unofficial complaints have you had made against you by colleagues?

A. I had a time this year at the college where I -- when the Dobbs decision happened last June I wanted to do a talk on campus so that the students could understand the new decision, how it impacted them, because we have -- as I said before, 60 to 70 percent of our students are athletes. I wanted to make sure they understood the NCAA policy as it relates to unplanned pregnancy. And eight of my colleagues at Barton campus wrote the administration and did not want me to present.

Q. Why did they not want you to present?

A. Sorry. I can answer. In their letter that they wrote they said it's because they felt like we -- they needed -- I would bring my pro-life perspective and not -- it needed to be balanced with someone who is pro-choice.

Q. Did you end up giving that talk?

A. I did give the talk. Instead of in October, I gave it in April.

Q. Did you end up -- did you end up giving your pro-life perspective to that talk?

A. No. As a matter of fact, my daughter was in attendance and she said if I didn't know you I wouldn't have known whether you were pro-life or pro-choice.

Q. Have you ever had a malpractice claim filed against you?

A. The one that I told you about earlier I have. When I was a chief resident, there was a claim that was filed and I was included on it. But right before the jury was being selected the case was dropped. And I believe that's the only one.

Q. And what was that dropped case regarding?

A. A baby that had cerebral palsy. You know, I don't know if it was cerebral palsy. But had some chronic medical illnesses and they -- I think they felt like we didn't do the c-section maybe fast enough, but it turned out that they dropped the case.

Q. Have you ever been disciplined by a licensing board?

A. No.

Q. Have you ever been subject to disciplinary proceedings by an employer?

A. No.

Q. Got it. Thank you. So we're going to switch gears a little bit.

A. Okay.

Q. Do you believe that national data underestimates complications from abortions?

A. Yes.

Q. Are you aware that the CDC has obtained data on abortion mortality from all 50 states?

A. I'm aware that there is voluntary reporting from the states.

Q. Other than voluntary reporting from the states, do you know what sources the CDC relies on to identify abortion-related deaths?

A. I don't know a complete list. I could go to the CDC and look it up, but not off the top of my head.

Q. Are you aware that they rely on state vital records?

A. I am aware that they rely on state vital records and that those vital records are also voluntary.

Q. Are you aware that the CDC relies on individual case reports by public health agencies?

A. Yes, I'm aware that public health agencies do report information.

Q. Are you aware that the CDC relies on data from state maternal mortality review committees?

A. I'm aware that some states have those committees. I don't believe all states have those committees.

Q. Are you aware though that for where those committees exist, that the CDC relies on their data?

A. Yes.

Q. Are you aware that the CDC relies on reports by private citizens?

A. I'm not aware of the complete list, no.

Q. Are you aware that the CDC relies on media reports to identify abortion-related deaths?

A. Did you say media?

Q. Yes.

A. No, I'm not aware of that.

Q. Are you aware that for each death that is possibly related to abortion the CDC requests clinical records and autopsy reports?

A. I'm not aware of all the sources in which the CDC uses. What I will say is I'm aware that none of it is mandatory. And -- sorry.

Q. Sorry. Go ahead.

A. And that there is -- there are a lot of holes in terms of the fact that we don't have to have -- we don't have mandatory abortion reporting data.

Q. So you were not aware that the CDC requests clinical records and autopsy reports for deaths possibly related to

abortion, correct?

MR. BOYLE: Objection. You can answer.

THE WITNESS: Once again, I may have read it, but I don't have that list in my head of everything. So I can't truthfully say to you all the places I'm aware that they get their data.

BY MS. SALVADOR:

Q. And are you aware that where the CDC reviews autopsy reports two epidemiologists review these reports to determine the cause of death and whether it was abortion related?

A. I'll repeat that I'm not aware of all the sources off the top of my head that the CDC uses.

Q. Is it your understanding that carrying a pregnancy to term carries more medical risk for the patient -- for the pregnant patient than having an abortion?

A. Could you say that one more time? You switched on me and --

Q. Sure. Is it your understanding that carrying a pregnancy to term carries more medical risk for the pregnant patient than having an abortion?

A. I disagree with that.

Q. So you disagree that carrying a pregnancy to term has more risk for the pregnant patient than having an abortion?

A. Yes. Because we have inaccurate data and so you -- that leads to inaccurate conclusions. The only -- when we

compare those two, it's very difficult when you have a data collection system that basically live birth is the only thing we know for sure because everybody has a birth certificate. And when you look at maternal mortality it is, you know, number of deaths per hundred thousand live births. And pregnancies don't just end in live births. You know, as a matter of fact in our country about 65 percent of pregnancies end in live birth. About 35 percent don't. And if you look at black women, almost half of their pregnancies don't. So you have a statistic in which the denominator -- we have 35 to 50 percent that we're not even accounting for the fact that those pregnancies can end in abortion, induced abortion, or natural losses or ectopics or hydatiform moles. So yeah, there are great limitations in how we collect our data.

Q. Do you accept that abortion is safer than child birth for most abortion patients?

A. I cannot make that conclusion given the data we have.

Q. Are there circumstances in which you would say that abortion is riskier than a pregnancy and child birth?

A. Could you repeat that for me, Anjali?

Q. Sure.

MS. SALVADOR: Could I actually ask the court reporter to read that back so the words are exactly the same.

- - -

(The requested portion was read back by the

reporter.)

- - -

THE WITNESS: So that's a hypothetical question. So it's difficult to know because circumstances often change. We know that abortion -- you know, the greatest predictors of complications and death from abortion -- induced abortion is gestational age. So it's very difficult to make a comparison of a pregnancy to an abortion.

BY MS. SALVADOR:

Q. Is it true that some people who get abortions would have experienced pregnancy complications if they had stayed pregnant?

A. Yes.

Q. The likelihood of pregnancy-related death is higher for women with certain preexisting conditions, isn't that right?

A. The likelihood of pregnancy-related deaths is higher for some women with preexisting conditions?

Q. Yes. Is that right?

A. That is correct.

Q. What sorts of conditions would increase the risk of death during pregnancy?

A. So certain types of cardiac issues. Women who have kidney failure are, you know, some of the worst mortality risks. You know, uncontrolled diabetes. When a woman has it

uncontrolled during pregnancy, uncontrolled hypertension. So various chronic diseases do make the pregnancy more difficult, which is why we have a subspecialty of maternal-fetal medicine and designed to care for those women and if we do our job well, we really can hopefully reduces those risks for her.

Q. And at least some of women with those preexisting conditions you have just named obtain abortions, is that right?

A. Yes.

Q. So in your declaration -- and I'll point you to -- it's the bottom of page 12.

A. Okay.

Q. Sorry, I'm going there myself. You write it is possible that the higher rate of induced abortion and later abortions in black women account for a portion of the racial disparity noted in pregnancy mortality, is that right?

A. You said page -- is it page or paragraph? I'm doing the hard copy here.

Q. Okay. Sorry. It's paragraph 25. It's the end of paragraph 25. And if anyone is looking at the page numbers, it's the bottom of page 12 of the PDF.

A. Just give me a second.

Q. Sure.

(Pause.)

A. Okay. I'm there.

Q. Okay. So the declaration says it is possible that the

higher rate of induced abortion and later abortions in black women account for a portion of the racial disparity noted in pregnancy mortality and this level actually be protected for black women.

Did I read that sentence correctly?

A. Yes.

Q. But you don't cite any sources for that statement, is that right?

A. No. It's based on the full paragraph in terms of the sentences before in that we know that black women have more abortions, induced abortions than white women. We also know their mortality rate is higher.

Q. When you say the mortality rate, you mean that we know that their maternal mortality is higher, is that right?

A. Yes. Well, the data suggests that, yeah, it is higher and that they have more second trimester abortions, later abortions, which we know have greater risk for complication and death. So the answer for woman -- black women to addressing maternal mortality is not more abortion. That's what I'm saying in this. It's really that we have to get to the root causes of why black women die and they're multifactorial, including chronic diseases, which we have talked about, but also health disparities that happen in their treatment of care. They're not often heard the same. And it also is access to early prenatal care, transportation issues, education about

warning signs. So my point in this paragraph is that the answer to help women who are black or white and have chronic disease is not to destroy their children. It's get to the root cause of why they're dying.

Q. But you're not aware of a source that draws a causal link between abortion-related mortality and the relatively high black maternal mortality rate, are you?

A. Not off the top of my head, no.

Q. So in your declaration -- and this is also in paragraph 25.

A. Okay.

Q. You state that the risk of death from induced abortion increases as gestation progresses, is that right?

A. Yes.

Q. And you cite a study by Bartlett, et al. for the idea that women whose abortions were performed in the second trimester were significantly more likely to die of abortion-related causes, is that right?

A. Yes, I do cite that study.

Q. Do you recall that that study found that for the time period it was discussing the overall death rate for women obtaining legally-induced abortion was 0.7 per 100,000 legal induced abortions?

A. I would need to look at the study. I don't recall those exact numbers.

Q. Sure. One second.

A. Can I -- I have a copy of it. Is it --

Q. Sure. You can use your copy.

MS. SALVADOR: And then I am dropping the digital copy into the chat right now. So could we please have that marked as an exhibit.

- - -

(Document marked as Exhibit-Q for identification.)

- - -

BY MS. SALVADOR:

Q. Dr. Bane, I'm going to ask you to pull up the digital copy too and just confirm that it's the same as what you're looking at.

A. Okay. Sorry, it's making me save it again.

Q. That's fine.

(Pause.)

A. Okay. It's the same.

Q. Okay. Great. And so this document is the Bartlett study that we were discussing, is that correct?

A. That's correct.

Q. So I'm going to point you to the first page, left hand column where it says results.

A. Okay.

Q. The first sentence there is during 1988 to 1997 the

overall death rate for women obtaining legally induced abortions was 0.7 per 100,000 legally-induced abortions.

Did I read that correctly?

A. You did.

Q. So do you recall that CDC data states that in 2021 the maternal mortality rate was 32.9 deaths per 100,000 live births?

A. No, I don't recall the exact number.

Q. One second, please.

MS. SALVADOR: So I'm dropping a document into the chat entitled 2021 Maternal Mortality Rates as the file name. Could we please have that marked as an exhibit and, Dr. Bane, could you please open it?

THE WITNESS: Sure.

- - -

(Document marked as Exhibit-R for identification.)

- - -

BY MS. SALVADOR:

Q. Just tell me when you have it open.

A. Just a sec. Let me try again.

Q. Sure.

A. Okay.

Q. If that doesn't work for you I can try to screen share it.

A. No. I actually got it and I actually think I have that same document.

Q. Okay. I just have a couple of questions about it, so if you have to find it, it might be easier to use the digital copy.

A. Okay. That will be fine.

Q. So is this document we're looking at the CDC data for maternal mortality rates in the United States for 2021?

A. Yes.

Q. So if you go to the second full paragraph on the first page.

A. Okay.

Q. Do you see that it says that the maternal mortality rate for 2021 was 32.9 deaths per 100,000 live births?

A. I do see that.

Q. And then do you see that at the very beginning of the next paragraph it says in 2021 the maternal mortality rate for non-Hispanic, black, in parentheses, subsequently black women was 69.9 deaths per 100,000 live births?

A. Yes.

Q. And in your declaration you also discuss a North Carolina Maternal Mortality Review report from 2021, is that correct?

A. Yes.

Q. Do you recall that the report states that in 2016 the

maternal mortality rate was 20.7 deaths per 100,000 live births?

A. I don't recall that number, but I have easy access to that document if you would like me to get it out.

Q. Sure.

MS. SALVADOR: I'm going to drop that into the chat as well. So if we could please have it marked as an exhibit.

- - -

(Document marked as Exhibit-S for identification.)

- - -

THE WITNESS: I have it.

BY MS. SALVADOR:

Q. And then, Dr. Bane, could you just please verify that the digital copy is the same as what you're looking at?

A. Okay. Let me look. Yes, it's the same.

Q. Okay. Thank you. Could you go to page 12 of that report, please.

A. Sure.

Q. So do you see on page 12 there is a paragraph that starts with pregnancy-related death ratios from 2007 to 2016. And the end of it says that the pregnancy-related death ratio is 20.7 deaths in 2016, is that right?

A. Yes.

Q. Are you familiar with the CDC's abortion surveillance data from 2020?

A. I looked at it, but I don't have it on the tip of my tongue. I would need to see it also.

Q. Got it. Thank you.

MS. SALVADOR: So I am dropping that into the chat as well. It's the file name entitled CDC Abortion Surveillance. If we could please have that marked as an exhibit and then, Dr. Bane, just let me know when you have it opened.

- - -

(Document marked as Exhibit-T for identification.)

- - -

THE WITNESS: Okay. I have it open.

BY MS. SALVADOR:

Q. Okay. And do you recognize this document as CDC Abortion Surveillance Data from 2020?

A. I have not seen this exact document. I have seen a summary. So I -- I --

Q. Okay. If you could go to the title page. Do you see there that it has the CDC logo at the bottom and then at the top it says Centers for Disease Control and Prevention, MMWR, Morbidity and Mortality Weekly Report, is that right?

A. Yes.

Q. Do you have any reason to believe that this document is -- or sorry. Do you have any reason to believe that this document is not the CDC abortion surveillance data from 2020?

A. No, I have no reason to believe that.

Q. So if you could please go to page 27 of the document.

A. All right.

Q. Let me know when you're there.

A. Okay.

Q. Do you see that it is -- it's a table labeled table 15, number of deaths in case fatality rate for abortion-related deaths reported to CDC by type of abortion, United States, 1973 to 2019?

A. Yes, I see that table.

Q. And then do you see that the far right column of that table is CFR, or case fatality rate, per 100,000 legal abortions?

A. Yes.

Q. And then do you see at the bottom right of the table that the fatality rate of abortions, according to the table, was 0.43 per 100,000 live births from 2013 to 2019?

A. I see that.

Q. Okay. Thank you. In your study and it's on -- it's in paragraph -- I'm sorry, not in your study. In your declaration in paragraph 33, you state that a study of 32 states in Mexico found that states with less permissive

abortion legislation exhibited lower maternal mortality rates overall, is that right?

A. Correct.

Q. But that study didn't know that restrictive abortion laws cause lower mortality rates, did it?

A. It was a correlation association.

Q. Right. So it didn't show causation, did it?

A. No. You can't do causation with induced abortion studies. You're not going to ever randomize people to an induced abortion. So yes, you have to do correlational studies.

Q. And didn't that study explicitly state that the initial estimated effects for all mortality outcomes were explained by differences in other independent factors known to influence maternal health rather than by abortion legislation itself?

A. I need to look -- pull it up. But I do not recall that -- I think it -- it recognized that it is multifactorial why women die. So, you know, any time you're doing a correlational study you're going to have to try to control for confounding factors. So we of course have to recognize that it's multifactorial.

Q. Understood.

MS. SALVADOR: So I am dropping the study itself into the chat. If we could please have it marked as an

exhibit and then, Dr. Bane, please let me know if you have it open.

- - -

(Document marked as Exhibit-U for identification.)

- - -

THE WITNESS: Yeah. Give me just a second. I'm trying to figure out in my -- did you say paragraph 33, right?

BY MS. SALVADOR:

Q. Of your declaration?

A. Uh-huh.

Q. Yes. Paragraph 33. But it goes on to the next page. Okay.

A. Okay. I'm just going to get that article.

Q. Yeah, I know it's hard to juggle these documents.

A. I was going to say, is there going to be a question at the end of all of this?

Q. There absolutely will.

A. I figured as much. I'm looking through my stack for that one. I'm a hard copy gal.

Q. Sure.

A. Okay. And you want me to confirm it's the same one, right?

Q. Yes, please.

A. Okay.

(Pause.)

A. Sorry, I'm having a hard time getting it to come up. So let's see. Okay. Let me just look. Okay.

Q. So is this the same study regarding abortion legislation in Mexico that we have been talking about?

A. It is.

Q. So could you please go to page 10 of the document and I'm using the numbers that are printed on the bottom right and left.

A. Yes. I'm there.

Q. Okay. So in the discussion there is a section that starts with discussion and then in the column on the right there's a long paragraph and it's kind of in the middle paragraph. So I'm going to read the sentence, nevertheless, after an exhaustive analysis adjusting for multiple cofounders, the initial estimated effects for all mortality outcomes were explained by differences in other independent factors known to influence maternal health rather than by abortion legislation itself.

Did I read that correctly?

MR. BOYLE: Object to form. I think you said cofounders and it's confounders.

MS. SALVADOR: I'm sorry, confounders.

THE WITNESS: Yes.

BY MS. SALVADOR:

Q. And going a little bit further down in that paragraph, there's a sentence that says consequently, making a direct or independent causal link between a less permissive abortion law and the lower incidence of maternal death, or conversely by considering a more permissive abortion law would be a premature or even erroneous conclusion. Is that right?

A. Yes.

Q. Okay. Thank you. And we're done with this particular study.

A. Okay.

Q. So going back to your declaration, paragraph 35. You cite a -- you state that medication abortions have a four times higher rate -- I'm sorry, four times higher risk of complications as compared to procedural abortions, is that right?

A. You're in paragraph 35 now?

Q. Yes.

A. Yes.

Q. And for that statement you're citing a study by -- there's a bunch of authors, but it's by Niinimaki, et al., is that right?

A. Yes. And then Mantula for the next statement, yes.

Q. Okay. So starting with Niinimaki, didn't the medication abortion group in that study include abortions

performed with Misoprostol alone?

A. Yes.

Q. Do you know whether PPSAT provides medication abortions using Misoprostol alone?

A. I would need to look again at the policies and procedures in order to answer that a hundred percent.

Q. And didn't the study describe both medication and procedural abortion as generally safe?

A. I don't know what you mean by generally safe.

Q. Sure. One second.

MS. SALVADOR: So I am dropping a document into the chat that starts -- the file name is Niinimaki, et al. Can we please mark it as an exhibit and then, Dr. Bane, let me know when you have it up, please.

- - -

(Document marked as Exhibit-V for identification.)

- - -

THE WITNESS: Okay. I have it up. I'm just going to get it out of my stack over here. Okay. I've got it.

BY MS. SALVADOR:

Q. And is the digital document the same as your hard copy document?

A. It is.

Q. And is that the same Niinimaki study that we were

discussing?

A. Yes.

Q. So could you please go to page 798?

A. Okay.

Q. Do you see that in the discussion -- right under the discussion heading the first sentence is in the present study we found that the two methods of pregnancy termination, medical and surgical, are generally safe, is that correct?

A. Just a second. I'm trying to -- I'm missing a page. So is that 798 you said?

Q. That's right. And if it's easier, I can also share my screen.

A. No, I have got it up on my screen. For some reason I don't have page 798 printed. So would you repeat that?

Q. Sure. Under the discussion heading, the first sentence right there is in the present study, we found that the two methods of pregnancy termination, medical and surgical, are generally safe.

Did I read that sentence correctly?

A. Yes.

Q. And are you aware that this study characterized all patient reports of heavy bleeding as hemorrhage even if they were within the expected range for medication abortion?

A. I'm aware that that's a limitation of the study.

Q. And are you aware that in response to criticism that

other literature about medical abortion reported a dramatically lower rate of complications that the authors of this study conceded that many of the complications are not really such, but rather concerns or adverse events that bring women back to the healthcare system?

MR. BOYLE: Object to form. You can answer.

THE WITNESS: So I'm aware just based on reading this study myself. I don't know about other conversations that I've had. But in reading it, I'm aware that there was probably some over reporting, which is a limitation. When you document in studies you always document limitations. And so I'm aware of that.

BY MS. SALVADOR:

Q. Are you aware that the study authors conceded that the rate of serious real complications is rare and rather similar between surgical and medical abortions?

A. I have no awareness that they have conceded that and this study has not been retracted.

Q. Understood.

MS. SALVADOR: I am dropping another document into the chat. The file name is Fjerstad-Niinimaki, letter to editor. Could we please mark it as an exhibit and then Dr. Bane, let me know when you have it open, please.

- - -

(Document marked as Exhibit-W for

identification.)

- - -

THE WITNESS: I have it open.

BY MS. SALVADOR:

Q. And you testified that you had reviewed Dr. Borass's declarations in this case, is that right?

A. Yes.

Q. And you also said that you reviewed some, but not all, of the literature she cited in her declarations, is that right?

A. Correct.

Q. Do you remember reviewing this particular document as one of the sources she cited in her declaration?

A. Not immediately, but I need to read it. Do you want me to do that?

Q. Sure. If you could just review. It says -- the relevant part is going to be that end reply column on the right.

A. Okay.

Q. And then it will go down to the next page.

(Pause.)

A. Okay. Thank you.

Q. So was the reply written by Niinimaki and the other coauthors of the study we're discussing?

A. Yes.

Q. And do you see at the bottom of page 660 on the right

that they write the main contributions that the present article makes to the literature are rate of serious and then in quotations, real. Complications is rare and rather similar between surgical and medical abortions?

A. I do see that.

Q. In your declaration you claim that there is a relationship between abortions and mental health complications, is that right?

A. Yes.

Q. And if you could go to paragraph 39 of your declaration.

A. Sure. Okay.

Q. So you describe a study by Mota or Mota and some others as discovering that abortion was associated with an increased likelihood of several mental disorders, substance abuse disorders, and suicidal ideation, is that right?

A. Yes.

Q. Is it true that in this study mental disorders were assessed by lay interviewers rather than by clinicians?

A. Let me get the study.

Q. Sure. And since you're looking at it, I'm going to put it in the chat and we'll mark it as an exhibit. Just one second.

- - -

(Document marked as Exhibit-X for

identification.)

- - -

THE WITNESS: Let me go to the chat and get it.

BY MS. SALVADOR:

Q. I'm sorry. I know it's tedious.

A. It's okay. I could use a potty break soon, just so y'all know.

Q. Okay. I just have a couple of questions about this study and then maybe we can take another break.

A. Okay. Let me just confirm it's the same study. Okay.

Q. So the study that you're looking at the hard copy of in the digital exhibit we just made, that's the same study, right, that we have been talking about?

A. Yes.

Q. And do you see on the first page there's a box there and it's got headings for clinical implications and limitations?

A. On the first page?

Q. Yeah.

A. I see that box, yes.

Q. And do you see that the first bullet point under limitations says mental disorders were assessed by lay interviewers?

A. I do see that.

Q. And then could you please go to page 245 of the study?

A. Okay.

Q. There's a heading that says conclusions. And then in the middle of that paragraph it says exposure to violence is a confounding factor in several of the associations between mental disorders and abortions.

Did I read that correctly?

A. I'm sorry, where -- you're on page 244 under the discussion?

Q. I'm sorry, 245 under the conclusion.

A. Oh, okay. Let me look on here. Okay.

Q. Should I repeat that question?

A. That would be nice. Thank you.

Q. Sure. So in that conclusion paragraph, in the middle of the paragraph it says exposure to violence is a confounding factor in several of the associations between mental disorders and abortions.

Did I read that correctly?

A. I'm sorry, Anjali, I don't see where that is.

Q. Okay. I'm going to just for this one --

A. I see it now. I see it now.

Q. Okay.

A. Yes.

Q. So yes, I read that correctly?

A. You did.

Q. And then do you see that the next sentence says our

study does not support a unidirectional relation between abortion and mental disorders?

A. Yes.

Q. And so this study didn't conclude that abortion caused the mental disorders it discusses, did it?

A. So, once again, when you do research, there are limitations and -- so when -- you're looking for associations and -- when it's correlational research of this type. And so you can't make the statement of cause and effect in this literature. What you can do though is note that there are lots of associations. It's similar to lung cancer. We can't say -- you can't say okay, you have to smoke for the next 20 years and you don't and we're going to see who gets cancer and the complications. But when you get an aggregate of data that consistently show those associations, that then allows you to draw inferences from that. So yes, you're talking about the Mota study, but there are hundreds of studies looking at the association. And yes, there are confounding variables, but we know how to control those in research and look for the impact -- you know, one of the strongest one is who I reference next, Dr. Fergusson who is openly pro-choice and he's greatly disturbed by the fact that his research shows me that women who have had an abortion when he looks at them longitudinally have similar to what this Mota study showed and, you know, his -- he had trouble publishing it, unfortunately, because sometimes the

conclusions aren't what journals want. But it would be scientifically irresponsible if I didn't. And so, you know, there are just so many articles in this literature to show that some women really do struggle with anxiety, depression, substance use disorder and suicidal ideations. So something that one in four women experience, I would think as a scientific community we would want know as much as possible for the safety and health and well-being of those women. So I think categorizing correlational research as not good research is a misnomer. We would never be able to say lung cancer is caused, you know, by cigarette smoking.

Q. For sure. And we'll get -- I know you wanted a break, so we'll get to the Fergusson study after the break. But just on this study, would you say that it's fair that one of the flaws of the particular Mota research used in this study is that it cannot concretely establish causation?

A. So it is a limitation in all correlational research that by itself causation -- it's not a randomized trial in which you have an abortion and you don't. So you cannot by itself say causation and that's not what I implied in my declaration.

Q. Got it. Thank you. And based on your experience as a physician, would you say that anxiety, depression, substance use and suicidal ideation are things that folks might struggle with after giving birth also?

A. Rarely.

Q. All right.

A. Yes. But I don't -- most women have tremendous amount of joy after giving birth. And so to equate that women who have a pregnancy loss of any kind, whether it's an abortion or a miscarriage, an ectopic, those women struggle in a different capacity than women who give birth.

Q. Okay. Thank you very much. We can take a break and go off the record.

VIDEOTAPE TECHNICIAN: Thank you.

MS. SALVADOR: 10 minutes.

VIDEOTAPE TECHNICIAN: We are now going off the video record. The time is 4:18 p.m.

(A break was taken.)

VIDEOTAPE TECHNICIAN: We are now back on the video record. The time is 4:29 p.m.

BY MS. SALVADOR:

Q. Okay. So Dr. Bane, we left off discussing paragraph 39 of your declaration and the studies you cite there.

A. Okay.

Q. So in your declaration you describe a study by Fergusson, et al. as finding that women who had abortions had 30 percent increased rates of mental disorders, is that right?

A. Yeah. Let me get that one.

Q. Sure.

(Pause.)

A. I got the right one.

Q. Could you define confounding in the research context, please.

A. Sure. So basically we know that many relationships are multifactorial. So in research you -- if you're trying to look at an association between two variables, you want to control for confounding variables, other things that might be associated. So in studies what you could do is you can control for those and see if a relationship still exists after controlling for those.

Q. Got it. Thank you. So didn't the study state, the Fergusson study state that the small association between abortion and mental health found in the study could be explained by uncontrolled residual confounding?

A. I would need to look at the sentence you're talking about.

Q. Okay. One second.

MS. SALVADOR: I am dropping the study into the chat. Can we please mark it as an exhibit. And then, Dr. Bane, if you can please confirm that we're all looking at the same thing.

THE WITNESS: Okay.

- - -

(Document marked as Exhibit-Y for

identification.)

- - -

THE WITNESS: Okay. They're the same.

BY MS. SALVADOR:

Q. Great. So if you go to page 450 of the study.

A. Sorry, my sheet was out of order. My page numbers got cut off when I printed it. Yes, the page with implications on it?

Q. Yes, that's right. So right before that implications heading, there's a sentence that starts in particular in that paragraph right before. And it says in particular, it could be suggested that the small association between abortion and mental health found in this study could be explained by uncontrolled residual confounding.

Did I read that correctly?

A. You read it correctly.

Q. Going back to your declaration. And we're still in paragraph 39. You also describe a study by Coleman as finding that adolescents who aborted an unwanted pregnancy were more likely than adolescents who delivered to seek psychological counseling and that they reported more frequent problems sleeping and more frequent marijuana use, is that correct?

A. Yes.

Q. Are you aware that Coleman's work on abortion and mental health has been heavily criticized by scientific

experts, including the Royal College of Psychiatrists?

A. I am quite aware that Dr. Coleman has had one study that was retracted. She also had another study that was attempted to be retracted and in her study that was attempted to be retracted, that study was then in -- I believe it was in the British Journal of Psychiatry, which is one of the highest impact factor publications, that they actually -- there was a group of people that wanted it retracted, they did an investigation and this is a very reputable journal and they kept it in there. I'm aware in the Frontiers of Psychology, I believe that's the one that retracted it, she did not even have the opportunity to give a rebuttal, which is extremely -- it's malpractice in research for that. And she has had a long career of a variety of studies that are in the literature and are well published and well respected. So I am quite aware that there is that one study.

Q. And would you say that retraction of the study is a fairly significant thing to have happen?

A. I am aware of retraction being a significant one. It's kind of like what I experienced at Barton College this year. They didn't like -- a group of people didn't like the fact that I was going to be sharing information that wasn't from -- it didn't have a conclusion that they particularly liked and they tried to retract and not allow me to talk. Fortunately my administration eventually allowed me, supported

me to talk. So I wish that she had had the opportunity to give -- to do what the other journal did and found there was nothing wrong in what she did. There has to be scientific integrity and sadly, she's being classified as somebody who doesn't have that when she has a tremendous amount to offer in her work.

Q. Generally speaking wouldn't you say that a scientific journal would not retract a study just because some people dislike it?

A. When I was training in my Ph.D. I would have said that, but I don't think that is necessarily true anymore. I think that a lot of the professional societies who print their own journals, they decide which studies to have in those journals. And, you know, we all have bias, all of us. And I gave a talk on diversity, equity and inclusion at this conference I'm at and I spoke about implicit bias and I said the most important thing is for us to be aware that we have it. And so in research every one of us on this call have biases and I'm aware that I have biases. As you said earlier, I'm a pro-life advocate. Okay. That should make me be an even better researcher because I know my biases and if I care more about the truth than I care about being right, then I can look at my research, my data, just like Dr. Coleman does, Dr. Fergusson who this study I cited, it took him four journals to get it accepted because they didn't like his conclusion. And he -- he basically is -- said I'm pro-choice. I didn't like my

results either, but I want women to be safe, so we need to publish my results. He said I get my stuff -- he's so internationally known he gets his research published the first try. It took him four tries to get a journal. So I get scared about where publication and the ability to publish when it goes against what certain professional organizations want to see.

Q. Just to be clear, just now you were talking about Dr. Fergusson and not Dr. Coleman, is that right?

A. I was talking about both of them. But Dr. Fergusson, I was talking about his article that I cited in my declaration took him four tries to get published and he -- it was very discouraging because of the fact that he is so well respect had. You know, there are certain people that when they submit and you're the author in a journal there, they are happy you chose their journal and he's one of those type people, yet his finding weren't consistent with what some wanted to get out there, which is very sad and scares me.

Q. Going back to the study -- the Coleman study that we were talking about, are you -- the one that you cited in your declaration, to be clear. Didn't the study also explicitly state that design limitations precluded definitive assumptions about causation for some of the same reasons that we talked about today?

A. Yes, it's -- once again, this whole body of literature is -- you can't randomize people to have an abortion or not.

And so you have to either retrospectively look back at charts or you can prospectively follow them. Which both Dr. Fergusson and Dr. Coleman's studies were longitudinal studies. They were prospective, which gives them great strength. But once again, because mental health issues are not going to necessarily -- they're going to be multifactorial, you can set up your study design to control for those and still see associations.

Q. And going back to your declaration. Again, we're still in paragraph 39. You also discuss a -- or, I'm sorry, we're now in paragraph 40. You also discuss a Finnish study showing a higher suicide rate after abortion when compared to giving birth, is that right?

A. I do.

Q. Are you aware of how the maternal mortality rate in Finland compares to the maternal mortality rate in the United States?

A. I would have to -- not off the top of my head, no. I would have to look at the study.

Q. Is it your opinion that abortion causes increased suicidality?

A. It is my opinion there's an association between abortion and suicidal ideation, as well as suicide. Once again, being an increased risk. So we know mental disorders, anxiety, particularly depression, and they can be comorbid,

meaning about half the people who have depression also have an element of anxiety, is a significant risk factor for suicide. And so it follows that if a woman struggles after an abortion with anxiety or depression, that could lead to suicidal ideation and suicide. So once again, the type of study is correlational and there's an association. But there are criteria so that if you continue over and over again to get the same correlational studies showing this, then that strengthens, as I said with the lung cancer example, that there is a very strong association.

Q. And to your knowledge is increased suicidal ideation ever associated with child birth for the period post-child birth?

A. Yes. So postpartum depression occurs and with the same rationale I just explained, a woman has postpartum depression would have an increased risk of suicidal ideation as well as suicide.

Q. And doesn't the Finnish study that you cite in your declaration also say social circumstances might be a common risk factor in terms of deaths from suicide and homicide?

A. I'll need to pull up the study.

Q. Sure.

MS. SALVADOR: So I'm dropping the study into the chat like we have been doing. If we could please mark it as an exhibit and then, Dr. Bane, please confirm that we're

looking at the same document.

- - -

(Document marked as Exhibit-Z for identification.)

- - -

THE WITNESS: Okay.

MR. BOYLE: I believe this one is already --

THE WITNESS: Yeah, it's not in my stack.

MR. BOYLE: You're talking about the Niinimaki study?

MS. SALVADOR: No, this is Karalis.

MR. BOYLE: Oh.

THE WITNESS: Just a second. Let me look. So paragraph 40. So number 28. Okay. My reference 28.

(Pause.)

THE WITNESS: I'm going to have to rely on yours. I misplaced it. We pulled out a lot of documents. Let me go to the chat.

BY MS. SALVADOR:

Q. We're almost to the end of the part that's heavy on studies so...

A. Okay. My desk looks like a mess over there. Okay. Oh, yeah. Okay. So where did you want me to look?

Q. So first, could you please confirm that this is the same Karalis study that you cite in your declaration?

A. It is.

Q. So could you please go to page 1119.

A. Okay.

Q. And under the sentence right before conclusion it says higher mortality rates after termination of pregnancy among teenagers, and especially deaths from suicide and homicide, indicate that women are very vulnerable at this stage and that social circumstances might be a common risk factor.

Did I read that correctly?

A. You read that correctly and it's consistent with all the other examples we have gone through of correlational studies. A design always in studies is, you know, when you present your research you're going to want to put the limitations and the confounding so that you're -- the reader knows you're not looking just narrowly. And, you know, they're highlighting the fact that suicides among teenagers, and especially deaths from suicide and homicide, while they increase, it's not going to be the only factor. So it's consistent with all the studies that are out there showing an association.

Q. Would you agree that it's important that studying and examining mental health and abortion control for the person's reason for getting an abortion?

A. Sure.

Q. Would you agree that someone who had an abortion of a

wanted pregnancy might have a different emotional reaction than someone who had an abortion of a pregnancy they didn't want?

A. We know that there are actually several factors. I didn't cite it in my declaration, but I believe -- I think it's up to 14 factors that are more commonly associated with mental health disorders and this doesn't just come from -- gosh, it's a text that looks at abortion and psychological impact. I can't recall it right now, but I could get the reference for you. But it is very commonly known that there are certain risk factors that are more associated with a risk for mental health issues afterwards and adjustment, negative emotions like anger and guilt. So yes, not every woman is exactly alike when it comes to her risk.

Q. Would you agree that a good comparison for studies examining mental health and abortion would be between people who wanted an abortion and got one versus people who wanted an abortion but couldn't get one?

A. So you're talking about the Turnaway Study, it sounds like. I think a better one is an -- comparing women who had an unwanted pregnancy or an unplanned let's -- let me correct that. An unplanned pregnancy, which is what I see all the time, and comparing women who had an abortion and women who chose to give birth and following them longitudinally. That is a much better comparison.

Q. So it sounds like you're familiar with the Turnaway

Study?

A. Yes. I don't have it in front of me, but yes, I am.

Q. And are you familiar with how the Turnaway Study was designed?

A. I'm familiar to the extent that they -- they provided their sampling plan. If you look in their very long document about it they don't actually give you very specifics and so that's a major limitation. And it's actually not a great research from the standpoint of one of the strengths of research is that it's reproducible. So I should be able to take their methods and replicate their methods and see what I find. That's when studies are stronger. And unfortunately they don't clarify that very well.

Q. And are you aware that Dr. Wubbenhorst, your fellow expert in this case, has referred to the Turnaway Study as extremely well designed?

A. No, I'm not aware of that.

Q. So you would not agree with that?

A. No, I would not.

Q. Got it. And are you aware that the American Psychological Association has said that research shows that having an abortion is not linked to mental health problems?

A. I am aware of their statement. I disagree with it, but I am aware of it.

Q. So you also state in your declaration that hemorrhage

is a risk of abortion, right? And this is in paragraph 35.

A. Did you say hemorrhage?

Q. Yes.

A. Okay. Sorry. You switched gears.

Q. I did. I'm sorry.

A. We're going to paragraph 35?

Q. Yes, we are.

A. Okay. I am aware that hemorrhage is a risk of abortion.

Q. I'm sorry, I didn't mean to cut you off.

A. Oh, no. No. You're fine.

Q. So in your opinion what amount of blood loss constitutes hemorrhage in the abortion context?

A. So we'll typically when a woman is bleeding say to her if you're filling two pads an hour full of blood for more than two hours is typically what I will tell them, I want you to call me. I'm concerned about that level of bleeding.

Q. And is there a risk of hemorrhage associated with childbirth as well?

A. Yes.

Q. Do you know whether the risk of hemorrhage is greater with carrying a pregnancy to term or abortion?

A. I don't know head-to-head studies that look at that particular thing. I know the average birth is -- a vaginal delivery is about 500 cc of blood. A c-section is more. And

so if a woman does not have hemorrhage you would expect much less than that. But if she has hemorrhage, it could be a wide range of amounts.

Q. So you don't know whether the risk of hemorrhage is greater with childbirth versus abortion?

A. I don't know of studies that have like -- I can't reference a study, so that's just a big generalization.

Q. Got it. And you state in your declaration also that infection is a risk of abortion, correct?

A. Yes.

Q. Is there a risk of infection associated with carrying to term in childbirth also?

A. Yes.

Q. Could you describe how that infection might arise in the childbirth context?

A. Yeah. So postpartum --- well, if we're talking about -- and if you could clarify, Anjali, that would help me. You're saying after a woman has had a baby or during her pregnancy?

Q. Both. Let's do both. So why don't you go one by one.

A. Okay. So I guess what I'll probably do just to not make this too long is what I'm talking about in my declaration is an infection after a pregnancy -- after an induced abortion. So probably just an infection after delivery. Because, I mean, a woman can get every type of infection during pregnancy that

she can get when she's not pregnant, plus she can get, for example, the chorioamnionitis that I mentioned also because she has a gestational sac that she wouldn't have when she's not pregnant. But after pregnancy women can get something called postpartum endometritis where they get an infection of the lining of the uterus and that infection -- when you think about the fact that the cervix opens to 10 centimeters to deliver a baby vaginally or by c-section that while it's a sterile environment, you still have the risk of infection. You're using instruments and things like that. So she can present with a fever. It's usually after she has gone home and she presents with a fever and sometimes abnormal discharge that's consistent with infection. And we treat it with antibiotics.

Q. Do you know whether the risk of endometritis is greater after childbirth like you have been describing or after an abortion?

A. No, I do not. And -- yeah. No.

Q. So it sounds like you have treated patients with endometritis, is that right?

A. I have.

Q. And you said you treated them with antibiotics, is that right?

A. Yes.

Q. Did that treatment always require hospitalization of the patient?

A. Not always.

Q. How often does that treatment require hospitalization?

A. I can't give you a percentage. I don't know the answer to that.

Q. Would you say more often than not you had to hospitalize those patients?

A. Yes.

Q. Do you think that endometritis can only be treated safely in a hospital?

A. I think you have to look at the clinical context and how sick the woman is and make a decision also how reliable she is and how -- whether or not she wants to go to the hospital. She's got a newborn now. You know, so I think that you can give her the option if you feel like she can be safely treated as an outpatient and check in with her. So I think you can give options.

Q. Okay. So in certain circumstances you can safely treat endometritis outside of the hospital setting, is that right?

A. Yeah. But it usually requires I.V. antibiotics typically. So the majority are in the hospital. I'm trying to think even now -- I think -- to be honest, I have to change my statement. I'm pretty sure we did everybody in the hospital. It's been over 10 years. There may be a protocol now for outpatient. I also think I was thinking about someone with

mastitis, which is infection in the breast. And we have treated a lot of those women as an outpatient.

Q. Got it. Thank you. So you also state in your declaration -- and now we're at paragraph 37.

A. All right.

Q. You also state in your declaration that a single induced abortion increases the risk of preterm birth, is that right?

A. Yes.

Q. And you cite a study by Hanes, et al., is that right?

A. Yes.

Q. But didn't that study also say that association between abortion and preterm birth may be due to chance or bias or confounding variables?

A. Once again, good researchers actually talk about limitations and recognize that preterm birth has many factors associated with it. So what they're trying to do is -- in this case it was a review of the literature and take all the different studies and -- that met the criteria for their metaanalysis and look at it recognizing that an association does exist, yet there are other factors that come into play.

Q. Right. So they recognize that the association could be due to chance, bias, or confounding variables, is that right?

A. They do recognize that. But they do also say that

there is consistent evidence that there's an association and it is a risk factor for preterm birth.

Q. Got it. Thank you. And your declaration also states in that same paragraph 37 that more than one abortion has been shown to increase the risk for preterm birth by 93 percent, is that right?

A. Yes.

Q. And that's the study by Shah, et al., is that right, or Shah and Zao?

A. Yes.

Q. But didn't that study also explicitly note that it doesn't establish that multiple abortions cause that increased risk, correct?

A. Let me get that study. Just a second.

Q. Sure.

MS. SALVADOR: And I'm going to put that in the chat as well and please mark that as an exhibit. And, Dr. Bane, please confirm that we're looking at the same thing.

THE WITNESS: Okay.

- - -

(Document marked as Exhibit-AA for identification.)

- - -

THE WITNESS: Yes, I have got the study now.

BY MS. SALVADOR:

Q. Okay. And it's the same study by Shah and Zao that we've been discussing?

A. It is.

Q. Okay. Could we go to page 1438, please.

A. I'm there.

Q. Okay. So if you go to the right column there is a heading that says implications for practice. And above that heading there is a long paragraph. And I'm going to read starting from the middle of it. So it says we must caution readers that we have restricted ourselves to explore the association of I-TOP -- I-TOP being previously defined as induced termination of pregnancy -- and pregnancy outcomes. Several biomedical, social, environmental, lifestyle-related, genetic and other factors contribute to a preterm and/or LBW -- that's low birth weight -- births and this needs to be kept in mind in interpreting our results. We caution interpretation being causal as confounding effects of socioeconomic factors, which are important, were considered in very few studies only. Discussion regarding downsides of I-TOP are incomplete without discussing downside of unwanted pregnancies as they are also at risk of adverse outcomes.

Did I read that correctly?

A. You did.

Q. So we have gone over a lot of studies. Have any of these studies that we have gone over lead you to want to modify

the opinions you state in your declarations -- in your declaration, I'm sorry?

A. No, they simply reinforce what I have repeatedly said this afternoon, that really good research recognizes the limitations of the research. But we also know that -- like for example, what you just read, if I was -- if I was a reviewer for this paper, I would be looking for that paragraph right there. And the fact that it is there and the fact that they acknowledge that it is there shows me that bias I was talking about earlier. They're trying to control for that. They're not in any way trying to say that this is a causal relationship. But once again, this is review of a lot of studies. And what I like about this is we know that the preterm birth rate is so high in this country. We also know that it's higher in black women. And we also know that black women have more abortions. And so wouldn't we care enough about black women and their children to want to really understand this relationship. So if indeed induced abortion is a contributing factor, not the only factor, but a contributing factor to why they're delivering premature children that have chronic diseases, because that's a risk factor of prematurity, not all of them have them, wouldn't we want women to know when they're making that decision about whether or not to give birth or to have an abortion. And so I -- I applaud these authors for doing that and so many of what you have cited just

reinforces that these are really important studies that I included and that the authors are doing good research.

Q. I got it. Thanks for your explanation. So we're going to switch gears a little bit. We talked a little bit about hemorrhage earlier. Did you ever treat patients who were hemorrhaging in your medical practice?

A. Yes.

Q. Under what circumstances?

A. Probably the most common would be postpartum hemorrhage. So a woman delivers a baby and then her bleeding doesn't slow down. It could also be that she had a placental abruption, which means the placenta comes off the edge of the uterine wall and she could bleed. She could have a placenta previa where the placenta is implanted over the internal os, which is the internal opening of the cervix, and she could bleed. Intraoperatively I dealt with hemorrhages in women. I particularly remember some traumas of pregnant women who were in car accidents, one in a train accident. Yeah.

Q. And in the labor and delivery context, I think you might have mentioned the number before, but in terms of the amount of blood, what do you mean by hemorrhage?

A. So, you know, in terms of labor and delivery, you know, it's not normal when you're not giving birth to bleed. And so, you know, the placenta accreta, the placental abruptions, these women are coming in and they're soaking pads

or, you know, they can't control the bleeding.

In terms of postpartum hemorrhage after a delivery, it would be -- I mentioned 500 ccs, but -- for a vaginal delivery. When you're in the middle of a postpartum hemorrhage, holy cow, the bleeding is so brisk because the -- a pregnant uterus, the blood vessels are -- particularly at term are very large. They're engorged. They have a lot of blood flow. So you have to act fast and you have -- in your head you have to go through your differential diagnosis. You know, do you have uterine atony, meaning the uterus is not contracting down to top -- when the uterus contracts down, it squeezes the blood vessels and helps. You have to think of that. You have to think is there a laceration in there. Is there some retained placenta in there. So you're differentially diagnosing while you're calling for treatment options.

Q. And have you ever treated patients who are hemorrhaging in the miscarriage management context?

A. So yes, I have. And the -- typically there we did most of our D&Cs in the operating room where we could use suction aspiration and often times control that well. But, you know, if they were still bleeding heavily, we would have to give them -- well, you can do uterine massage, you can give medicines that help contract the uterus, things like that.

Q. So you said you handled most of your D&Cs in the operating room. So where would the other -- where else would

you handle D&Cs?

A. Oh, so what I meant is some that do expectant management. I never did D&Cs in the outpatient setting.

Q. And would the definition of hemorrhage for a D&C be a different amount than the labor and delivery amount we just talked about?

A. Yes, it would be less typically.

Q. About how much?

A. I would probably say 200 cc.

Q. Do you think that hemorrhage can only ever be treated safely in hospitals?

A. I think that --

MR. BOYLE: Objection to form. You can answer.

THE WITNESS: Okay. I think hospitals are much more equipped to handle hemorrhage, particularly with a pregnant uterus. And the risk of uterine atony that we can have with it and lacerations, I think hospitals have the resources they -- if I need to do an immediate transfusion they have blood banks, they have -- if she bleeds so much that she needs support from an ICU team, if she were to, God forbid, code, they have code teams there. I have anesthesiologists that can intubate her and nurse anesthetists. So I think that every pregnant woman's life matters and because of that I want her, should I have hemorrhaging, to be near the resources that can best save her life.

BY MS. SALVADOR:

Q. Do you think a hemorrhage of 200 cc can be treated safely in an outpatient setting?

MR. BOYLE: Object to form.

THE WITNESS: I think that if you -- so when I said 200 cc, what I'm talking about is maybe she initially comes in and complains and has 200 cc, but it's not like then it's turned off. She's continuing to bleed. And so, you know, I have reviewed the protocols that Planned Parenthood -- PPS -- I'm sorry, the acronym you said at the beginning -- southern states has. And it's obvious that they do have protocols, but it's obvious that they recognize that they can have an awful lot of hemorrhaging because their protocols are very, you know, multilayered that go way beyond what you would do if there was 200 cc of loss only.

BY MS. SALVADOR:

Q. In your medical practice have you ever treated patients with cervical tears or lacerations?

A. I have.

Q. Under what circumstances?

A. Usually childbirth is where you can have it. I'm trying to think if any other times that I recall cervical lacerations. When you're dilating the cervix using the dilators, which are metal instruments that you sequentially dilate the cervix when you're doing a D&C, you can have a

laceration from that.

Q. Got it. And so -- and then you said before also that all of your D&Cs you would perform in a hospital setting, is that right?

A. Correct.

Q. Is it your opinion that cervical tears can only be treated safely in a hospital?

A. It's my opinion that cervical tears bleed really rapidly and that I would not try to be -- in a hospital setting your ability to visualize, you have to picture your -- the cervix is, you know, four, five centimeters inside the vaginal canal. And so if you're in an office setting, to try to visualize it and control the blood is a lot more difficult than it is in a hospital. So as much as anything, yes, you have the resources if you can't get the bleeding to stop in a hospital, but you also have the ability in terms of -- with the amount of blood loss I have seen with cervical tears to just have, you know, the surgical packs that are available to help you have the instrumentation that you need.

Q. I'm sorry, that isn't quite what I asked. So I asked whether you think that cervical tears can only ever be treated safely in hospitals?

A. No. I think that if you have a cervical tear -- and I'm just trying to recall if I ever had a cervical tear when I was in my office that I had to try to repair that -- I think it

would be harder. But I think that if you had to repair it, you would do the best you could. But it would be more difficult without having the instrumentation.

Q. And you mentioned doing a D&C with four to five centimeters of dilatation. Do you always have to dilate to that amount when you're doing a D&C?

A. No. I'm sorry, that's not what I said. Maybe it sounded like what I said. I apologize. Let me fix that. The cervix is four to five centimeters like in the vaginal canal. So you have to put a speculum in and it's not like the cervix is right at the opening. It's deep in the canal. So no, no, you do not have to dilate four to five centimeters. I was just saying from a landmark perspective the cervix -- if you have a cervical laceration you have to get deep into the vagina. And so visualization -- you're not just going to start throwing stitches without seeing where you think your source of the bleeding is and that's difficult because the cervix is so far away.

Q. Understood. Thank you for clarifying.

A. You're welcome.

Q. Did you ever use sedation in your medical practice?

A. Not that I was overseeing. The nurse anesthetist or the anesthesiologist was overseeing the sedation because that's out of the scope of my practice.

Q. And what types of sedation were you overseeing? I'm

sorry, you said you were not overseeing, is that right?

A. So it depends -- I guess I should clarify. If somebody was -- let's say she was coming in for something called a LEEP procedure or a colposcopy procedure, which is what we use to manage abnormal Pap smears, and she just said I'm really anxious. Like I would go to the radiology department and do something called a hysterosalpingogram to look for whether tubes were opened or closed for women who had infertility. If she said to me I'm really anxious then I would give her potentially something called a benzodiazapine, which is an over-the-counter medicine for anxiety. That could be categorized as like very mild sedation. But I would give those to women who potentially had an anxiety disorder. What I think I want to just make sure I clarify is that I don't think it's the role of an obstetrician and gynecologist to manage deeper levels of sedation that anesthesiologists, nurse anesthetists are specifically trained to do.

Q. And so for those patients who you would prescribe benzos, was that ever in an outpatient facility?

A. Yes, it would potentially be in the office, that they would get -- you know, 30 minutes before their procedure that they would get that medicine.

Q. And were you able to administer that medicine safely in an outpatient facility?

A. So they -- I didn't administer it. I would write a

prescription and they would take it before they came. So if that's your definition of administer it, then yes, I was for those situations.

Q. And did you ever supervise the use of I.V. sedation?

A. I did not.

Q. And did you ever supervise the use of kind of local anesthesia?

A. So I use local anesthesia. So, for example, if you're doing a procedure in the office sometimes we would put it in the cervix. If we're removing like a -- doing a vulvar biopsy. So I would do local anesthesia, yes. But not any sort of systemic anesthesia. That's what I'm referencing to. I think that's out of the scope of the practice of anyone but an anesthesiologist and nurse anesthetist.

Q. Understood. And that local -- that local anesthesia that you're referring to, you were able to administer that in an outpatient facility?

A. I was.

Q. So we're going to switch gears a little bit. What is an ectopic pregnancy?

A. An ectopic pregnancy is a pregnancy that is outside of the uterine cavity. It can be -- well, most commonly it's in the fallopian tube, but it can occur in other places such as the ovary, can even be intraabdominal, cervical.

Q. And how are ectopic pregnancies detected?

A. Ectopic pregnancies are detected by ultrasound.

Q. Would you agree that an ectopic screening protocol that uses ultrasound, the patient's medical history, and hCG testing is an appropriate protocol?

A. So you said three things. You said ultrasound, history and hCG?

Q. That's right.

A. So I follow the protocol from ACOG and I think it's a committee opinion or a Practical Bulletin 191. It got updated to 193. I think I used 191 in my declaration. There's an updated 193 and I follow their protocol which includes, yes, doing those things to document whether an individual has an ectopic pregnancy.

Q. And how early can ultrasounds detect pregnancy?

A. We can usually see a gestational sac about five weeks. It doesn't confirm that it's not an intrauterine pregnancy just to see a sac. So we have to be cautious with that because you can something called a pseudosac with an ectopic pregnancy. You can also have what's called a heterotopic pregnancy, which is fortunately very rare, but it's an intrauterine pregnancy and an ectopic pregnancy at the same time.

Q. What is a pregnancy of unknown location?

A. So a pregnancy of unknown location is a transient situation. It not a diagnosis. It is where you don't know exactly if the person -- if the woman has as intrauterine

pregnancy or an ectopic. So you have to have a high clinical suspicion when you have -- any time you have a pregnant patient you have to have a high clinical suspicion that she has an ectopic until you prove otherwise. But particularly if you were expecting to see an intrauterine pregnancy based on a sure last menstrual period for example, which we know unfortunately only happens about 50 percent of the time. A lot of women don't know their last menstrual period. But yeah, it's particularly important that we follow those women who have pregnancy of unknown location because we really -- for her safety we haven't confirmed where her pregnancy is located.

Q. So you wouldn't consider a pregnancy of unknown location equivalent to a confirmed ectopic then, would you?

A. No, I would not. I would basically have a high clinical suspicion until proven otherwise that she had an ectopic. If she has an intrauterine pregnancy I'm not going to send her home and she potentially die on me. But if she has an ectopic pregnancy and I send her home she could rupture that and unfortunately it's one of the leading causes of maternal mortality in the first trimester.

Q. So is it your medical opinion that all pregnancies should be assumed to be ectopic until proven otherwise?

A. It is my medical opinion than I want to document every pregnancy to confirm an IUP and that gives me a great sense of reassurance. So yes, I think all pregnancies we have to

document that we have an IUP.

Q. If a pregnancy has -- sorry. If a patient has a pregnancy of unknown location --

A. Okay.

Q. -- but doesn't have symptoms of ectopic pregnancy and doesn't have risk factors for ectopic pregnancy in their medical history --

A. Okay.

Q. -- would you consider that a suspected ectopic pregnancy?

A. So we know that 50 percent of our patients who have no risk factors have ectopic pregnancies. So the standard of care is not screening them. And so yes, I would still be very concerned and want to make sure she has an intrauterine pregnancy.

Q. So you would consider that a suspected ectopic pregnancy then, just to make sure I understand your answer?

A. Could you give me the clinical situation again?

Q. Sure. So if a patient has a pregnancy of unknown location, has no symptoms of ectopic pregnancy, no risk factors for ectopic pregnancy indicated in their medical history, would you consider that a suspected ectopic?

A. I would consider -- I would have a certain level of clinical suspicion, but often times when I document I will say I have a low level of clinical suspicion or I have a higher

level of clinical suspicion, but there is suspicion there because I have not proven that she has an intrauterine pregnancy.

Q. Got it. Thank you. I'm sorry, I was just trying to find your declaration again because I accidently closed a tab. So let's go to paragraph 61 of your declaration.

A. Okay. I'm there.

Q. So in paragraph 61 of your declaration you state that people who receive abortion medication without an ultrasound may result and delay detection and treatment of an ectopic pregnancy, is that right?

A. I state the pregnant woman with an ectopic -- oh, yes. Yes.

Q. Sorry, I should have clarified where I was starting to quote. So the quote is women who desire an induced abortion and receive abortion medications Mifepistone and Misoprostol without an ultrasound may result in delayed detection and treatment of an ectopic pregnancy.

Did I read that correctly?

A. Yes.

Q. Is it your understanding that PPSAT uses a patient's recollection of their last menstrual period alone to date a pregnancy?

A. I would have to look at their documentation.

Q. Okay. So you're not sure?

A. No. I know that they -- based on what I reviewed, that they use last menstrual period. And I am aware that they do give Mifepistone and Misoprostol without -- on the same day sometimes without a documented IUP, if that's your question.

Q. So is it your understanding then that PPSAT provides medication abortion to patients with pregnancies of unknown location without those patients having an ultrasound?

A. I am aware of that and it bothers me. It's -- I don't think it's standard of care and it's inconsistent with ACOG'S recommendations in Practice Bulletin 193.

Q. Is it your understanding that PPSAT uses hCG levels alone to diagnose ectopic pregnancy?

A. They have an algorithm, but I would have to review the algorithm when you say hCG along.

Q. So I'll just point you to paragraph 62 of your declaration.

A. Okay.

Q. So it says they falsely claim that hCG levels alone can be used to diagnose an ectopic, is that right?

A. So I'm talking about what the witnesses say with protocols using Mifepistone and Misoprostol that are inconsistent with practice guideline 193. So when I say using it alone, they're not using an ultrasound with it.

Q. Okay. Got it. So in your declaration discussion of the IUP -- the intrauterine pregnancy requirement, you rely

heavily on ACOG'S practice bulletin on tubal ectopic pregnancy, is that right?

A. Yes, I do.

Q. And I believe the document you cite in your declaration is Practice Bulletin 191, isn't that right?

A. Yes. They did an update and I did not include that update, but I have reviewed 193, which is actually -- I think they updated it two months after and I did 191.

Q. From what you remember, how does the update differ from the protocol you cite -- I'm sorry, from the bulletin you cite in your declaration?

A. I have it. Let me look. I have both of them.

Q. I'm just going to ask you generally what you remember, because we don't have that as a cited document in your declaration. So if you remember and if you don't, that's fine.

A. I think there is -- I don't remember exactly. It was just on one page they clarified something, but I honestly -- without looking at it I can't tell you exactly what that paragraph said.

Q. But generally speaking do you stand by, you know, the discussion of intrauterine pregnancy and ectopic pregnancy that's in your declaration?

A. Yes, I do.

MR. BOYLE: We have been going for about an hour. If you're getting close to the end, we don't need to

break. But if you're going to go for more than, say, 15 minutes I would request a break, please.

MS. SALVADOR: Yeah, we can break now. We're going to talk about the bulletin, but we can do that after we come back.

VIDEOTAPE TECHNICIAN: We are now going off the video record. The time is 5:29 p.m.

(A break was taken.)

VIDEOTAPE TECHNICIAN: We are now back on the video record. The time is 5:40 p.m.

BY MS. SALVADOR:

Q. Okay. Dr. Bane, we were discussing ACOG's practice bulletin on tubal ectopic pregnancy. According to the bulletin the minimum diagnostic evaluation of a suspected ectopic pregnancy is a transvaginal ultrasound evaluation to confirm the pregnancy, is that right?

A. Can I just get the document?

Q. Sure.

MS. SALVADOR: For the folks on Zoom, I am dropping the document into the chat. Attempting to drop the document into the chat. I'm dropping the document into the chat and then can we please have it marked as an exhibit and then Dr. Bane can just confirm that we're looking at the same thing.

- - -

(Document marked as Exhibit-BB for identification.)

- - -

THE WITNESS: Yes, we are.

BY MS. SALVADOR:

Q. Okay. On this document is the ACOG bulletin that we have been discussing, correct?

MR. BOYLE: Object to form.

THE WITNESS: Yes.

BY MS. SALVADOR:

Q. It's the ACOG Practice Bulletin 191 on tubal ectopic pregnancy, is that right?

A. Yes.

Q. Okay. So if you go to page E66. Let me know when you're there.

A. I'm there.

Q. So there's a heading that says Clinical Considerations and Recommendations. And then there's a subheading that says how is an ectopic pregnancy diagnosed. And then the first sentence right after that is the minimum diagnostic evaluation of a suspected ectopic pregnancy is a transvaginal ultrasound evaluation and confirmation of pregnancy, is that correct?

A. Yes.

Q. Do you agree that that statement is discussing the evaluation of a suspected ectopic pregnancy?

A. So consistent with what I said before, yes, it has the word suspected and because on page E65 of the same bulletin under risk factors it says one half of all women who receive a diagnosis of an ectopic do not have known risk factors. As a clinician who really wants my patients to be safe, every single one of them is a suspected IUP until I have confirmed otherwise. I will honestly tell you that every woman that walks in my door now and in the past I needed to know where her pregnancy was because of the risk of death of an ectopic.

Q. But the bulletin itself doesn't directly say that a transvaginal ultrasound evaluation is required when an ectopic pregnancy is not suspected, correct?

A. So it's speaking about how do we take care of our patients with -- associated with tubal ectopics. And so, you know, it starts off with the background, risk factors, epidemiology, and then it gives us our clinical recommendations. And included in that very clearly is that an ultrasound is central to that, as well as following hCG levels. But an ultrasound is central to it.

Q. But the clinical -- actually, strike that. So in your career, in your medical practice, did you perform ultrasounds?

A. Yes, I did.

Q. How early in pregnancy would you perform ultrasounds?

A. So, you know, a lot of it depended on the clinical scenario. But if she was coming in for just confirmation of

gestational age, we can usually do a crown rump length about five weeks and five days. So five to six weeks would be the earliest. But, you know, so -- so that's in that clinical scenario. I may do -- I may do it at a different time, you know, in a different scenario. But the earliest I can usually confirm a documented IUP with an embryo is going to be five to six weeks. We know that if you see a gestational sac that also has a yolk sac in it, that's also -- and you can see that before -- like earlier in the five weeks, that's also very reassuring that you don't have an ectopic pregnancy. You may not have a viable pregnancy if you only see the yolk sac, meaning you haven't confirmed fetal heart rate or seen the embryo, yeah.

Q. Did it ever occur in your medical practice where a patient had a positive pregnancy test but an ultrasound did not detect a pregnancy?

A. Sure. Meaning we did an ultrasound and we didn't see anything?

Q. That's right.

A. Yes. So that would be that pregnancy of unknown location.

Q. So what would your next step be in treating such a patient?

A. It would basically be if -- if she were coming in and she had a positive pregnancy test and she was completely

asymptomatic and she, you know, was just there for prenatal care, we would typically wait until she was six to seven weeks and do an ultrasound at that point. If she was coming in with a complaint then we would -- depending on the complaint. But if it was a complaint that for example, abdominal pain or some bleeding, you know, depending on how far along she was, we would do an ultrasound potentially then and then do hCG levels, so draw blood.

Q. And would you refer that patient to the emergency room?

A. No. I would usually manage her. I would refer her to the emergency room if I thought that she had -- if she was unstable or she potentially needed to be observed in the hospital. If she needed to have surgery. But that's not the clinical scenario I gave you. So that's why I would say no. But, yeah, if she was unstable and/or she was -- you know, I was worried that she had a ruptured ectopic at that moment, most definitely I would.

Q. So you shifted over to talking about a patient who was unstable, but before that you were talking about a patient who was stable. So for those stable patients, would you recommend that they return to your clinic for followup?

A. Most definitely we would follow their hCG levels and get what are called serial hCG levels. We would also do a repeat ultrasound.

Q. Did it ever happen that those patients didn't show up for followup at the schedule you recommended?

A. I can't -- I can't picture -- think of a patient off the top of my head. I was also in a large practice where sometimes they didn't follow up with the same person, but if I had somebody that I was following up, I would make sure that, you know, I was coordinating her care with one of my partners. There's not a patient that I -- that jumps out because you don't sleep. I mean, you're taught early in your ob rotations that a woman that you're concerned with a high level of suspicion for an ectopic you don't go to sleep on because she might go to sleep and die. So those are the women that I'm following very closely. But I can't tell you about a patient who didn't come back, off the top of my head.

Q. So what happens if an ectopic pregnancy ruptures?

A. So if an ectopic pregnancy ruptures a woman will -- and I'll say from let's say a tubal pregnancy -- she will typically have pain. We have two tubes, a left and a right. So sometimes that pain is one-sided. It can become in her entire abdomen though because she will start to bleed and she can actually fill her abdomen with blood and blood is very irritating to the peritoneal lining. And she can have just generalized abdominal pain. She can also -- if she's like filling her abdomen with blood she can actually get blood under the diaphragm that irritates the diaphragm and can even have

referred shoulder pain. Those are the women that have a high risk of dying because our abdomen has the ability to hold an awful lot of blood. Some of the women will have some bleeding but it's usually not heavy, heavy bleeding like a miscarriage type of bleeding. But they can complain of spotting too.

Q. Got it. So you said a lot just there. So I'm going to ask about some details of what you just said.

A. Okay.

Q. So you mentioned that the pain typically starts as a sharp pain on one side of the abdomen, is that right?

A. So, I mean, I have seen it present in lots of different ways. But when a woman comes into me, she's got pain on one side or the other, you know, my differential diagnosis -- and I know she's pregnant, you know, it can be appendicitis, it can be a ruptured ovarian cyst. If I haven't confirmed an intrauterine pregnancy it can be an ectopic pregnancy. And it usually, I would say, is one-sided, but I have seen it present with just lower abdominal pain. I'm absolutely amazed -- and maybe this is judgemental on my part because I feel like I know my body really well -- how poorly some women and men, my husband being one, to try to describe like is this muscle pain, is this a different type of pain. And so, you know, I am going to assume it's an ectopic if I have a pregnancy of unknown location until otherwise proven.

Q. I got it. Thank you. And would those -- would

patients suffering -- I'm sorry, let me rephrase that. So would that pain typically be a sharp pain or more of like a cramping type of pain?

A. So I have heard women describe it as both. But I do think one-sided sharp pain is a presentation I would get for sure. But I have also heard women talk about cramping pain. When I hear them say sharp pain, you know, it perks my ears up to an ectopic. But my concern is that it presents not just in one way, from my clinical experience. And so I can't differentiate out blood in the abdomen, it fills the abdomen can feel different for different people.

Q. Got it. And would somebody suffering ectopic rupture ever feel a popping sensation or anything like that?

A. You know, I have actually not had a woman use that terminology with me. I have heard people with appendicitis after it ruptures actually for a little bit have a sense of relief, but I -- I honestly have never had anyone describe it as popping.

Q. And you mentioned that there is bleeding and I -- I don't want to put words in your mouth. I think you characterized it as mostly internal bleeding at first, is that right?

A. No, not necessarily at first. A woman can come into me and have spotting, bleeding and not have a ruptured ectopic at that point. She may have a small amount of bleeding and we

can actually look on ultrasound. That's one of the things you can look for. It talks about this in Practice Bulletin 191, ultrasound finding of fluid in the cul-de-sac. So the cul-de-sac is kind of in the lower part of the pelvis behind the uterus and -- so when I see blood in the cul-de-sac, which is in the abdomen, so not coming out the vagina but inside the woman's peritoneal cavity, that I have to pay attention to when I see it. Sometimes you can have a ruptured ovarian cyst that can cause that and sometimes a little bit can be normal to see. But if I have a woman who is -- I'm concerned about with asymptomatic and I see that on the ultrasound, I don't see an intrauterine pregnancy, even if I don't see a mass in the adnexa, the adnexa would be the left and right side of the lower pelvis, but I see fluid in the cul-de-sac, that would concern me for some blood there. But in terms of vaginal bleeding, women can have spotting, but they can have a little bit of heavier bleeding. But it is true that I'd characterize the bleeding of a miscarriage, the soaking pads I don't see as much in ectopic as I see in miscarriages.

Q. Got it. Thank you. Would it surprise you to learn that PPSAT does not provide medication abortion if a patient has not had an ultrasound?

A. Say that one more time.

Q. Sure. Would it surprise you to learn that PPSAT doesn't provide medication abortion if a patient hasn't had an

ultrasound?

A. You're doing a double negative there and we're on the fourth hour.

Q. Sure.

A. Ask me that one more time at the end. Doesn't and doesn't it you said.

Q. Sure. I'll ask it the other way. Would it surprise you to learn that all of PPSAT's medication abortion patients have had ultrasounds before receiving the medication abortion?

A. Would it surprise me? I would have expected them to all have had them to confirm an IUD -- IUP because it's contraindicated to use Mifepistone and Misoprostol without excluding an IUP. That's straight from the prescribing information from the FDA, that you have -- you have to exclude it. So I was very surprised when I received their protocols and they actually do that. And I read in Dr. Farris I think is where I read it first. I was very surprised that they do that.

Q. So we're going to change gears a little bit here and we're going to go to your current work.

A. Oh, okay.

Q. So you're a member of the National Medical Advisory Board of Care Net, is that right?

A. I am. And I'm at the Care Net conference right now.

Q. So what is Care Net?

A. Care Net is a Christian organization that helps

support men and women who face an unplanned pregnancy with resources to help them know that they can choose life. So life-affirming choices.

Q. So what is Care Net's position on abortion?

A. Induced abortion is never indicated.

Q. What are your duties as a member of Care Net's national medical and advisory board entail?

A. The national medical director of the board is Dr. Sandy Christiansen and she will ask our opinions regarding maybe language that is clear -- this is an organization that helps the thousands of Pregnancy Centers across the country provide exceptional care to our clients and patients. Many of those organizations -- all the organizations started as really client advocacy -- helping with those socioeconomic barriers for women. But in I think it was the '90s they began also having medical clinics. And so those of us on the medical board help to guide centers who have medical clinics.

Q. So you mentioned that you're at the Care Net national conference right now, right?

A. I am, in Mobile, Alabama.

Q. I think you mentioned that you lead a couple of breakout sessions, is that right?

A. Yes. Yesterday I did one on diversity, equity and inclusion in Pregnancy Centers and today I did it on stress, burnout, compassion, satisfaction, compassion fatigue.

Q. And according to your C.V. you gave a keynote presentation at the Care Net national conference last year, is that right?

A. Well, I got COVID and didn't get to come. So -- but they prerecorded it and -- what did I -- what was it on? I can't remember the exact title. But yes, they did show my prerecorded talk.

Q. So your C.V. says the title was the Science of Decisionmaking, Implications for Pregnancy Centers, is that right?

A. Yeah. That rings a bell now. Thank you.

Q. Do you remember whether that presentation discussed abortion?

A. Okay. Let me think through. So a big part of it was really looking at -- yeah. I mean, it did. But I would have to go back to that to look at the details of it. But yes, there was -- it was -- the big picture of healthcare in general and our role as -- like really healthcare practitioners, our role of -- we're really journeying with these women. We are partnering with them. They bring their own life experiences. They bring their expertise and their own bodies and we bring medical expertise to the table. And it's not our job to make their decision. It's not our job to -- they're not broken. It's not our job to try to fix them. It's not our job to judge them should they choose abortion. It's really our job to

empower them with information and to really partner with them. And so I brought up a lot of concepts. I trained I think it was '21/'22 at Duke Divinity School. I completed a certification in theology medicine and culture looking at the intersection of religion and medicine and a lot of what I shared were some of the concepts I learned there.

Q. Got it. Thank you. And you're currently the medical director of three different organizations, is that right?

A. Three different Pregnancy Centers.

Q. Okay. Could you name those three Pregnancy Centers, please.

A. Sure. So Choices Women's Center is in Wilson, North Carolina. And Albemarle Pregnancy Resource Center and Clinic in Elizabeth City, North Carolina. And then Waterlife Pregnancy Center which is in the Outer Banks in North Carolina.

Q. Got it. Thanks. And all three of those Pregnancy Centers are affiliated with Care Net, is that right?

A. They are.

Q. So that means that they all have to sign a Care Net affiliation agreement, is that right?

A. They do.

MS. SALVADOR: So I am dropping a document into the chat and then if we could please mark it as an exhibit.

- - -

(Document marked as Exhibit-CC for

identification.)

- - -

BY MS. SALVADOR:

Q. Dr. Bane, let me know when you have this pulled up.

A. Okay.

Q. Are you familiar with this document?

A. I am familiar. I'm not sure if it's the exact one that all three of the centers sign. I'd have to look at it. I don't know how old this one is.

Q. Sure. But this document is a Care Net affiliation agreement, is that right?

A. That's its title, yes.

Q. And all three of the Pregnancy Centers you work at would have signed some version of this agreement, is that right?

A. Yes.

Q. And are they required to remain in compliance with the agreement they signed in order to remain affiliated with Care Net?

A. That would be my assumption. I have never known -- been involved in a practice that, like, Care Net kicked out.

Q. Got it. So number one on the document states the Pregnancy Center concurs with each and every affirmation set forth in the statement of faith attached hereto and incorporated herein by reference. The Pregnancy Center will

not engage the services of any board member, director, or volunteer who does not concur with each and every such affirmation.

Did I read that correctly?

A. You did.

Q. And so did all three of the Pregnancy Centers where you work concur with the statement of faith?

A. I know the one in Wilson did. I honestly don't know about the other two in terms of -- I would assume they did since they're affiliated with Care Net. But I cannot -- I have not laid my eyes on this document.

Q. I understand. But all three -- you said all three are Care Net affiliates, right?

A. Yes.

Q. And you have no reason to believe that they did not sign something like this?

A. Correct.

MS. SALVADOR: So I am dropping another document into the chat. The file name is Care Net Statement of Faith. Please mark it as an exhibit and then, Dr. Bane, let me know when you have it open.

- - -

(Document marked as Exhibit-DD for identification.)

- - -

THE WITNESS: Thank you.

BY MS. SALVADOR:

Q. Okay. Do you recognize this document?

A. Let me read it.

Q. Sure.

(Pause.)

A. I do recognize it.

Q. So what is this document?

A. Care Net Statement of Faith.

Q. So all three of the Pregnancy Centers where you work have certified that they concur with the Statement of Faith, is that right?

A. I can only speak specifically for Wilson because I have not had a conversation about Care Net -- the executive director's decision to be a Care Net-affiliated center. I have spoken directly with my center before I signed this. I am Catholic and number one, we believe the bible to be the inspired and only infallible authoritative word of God in the Catholic Church. The Catholic Church also believes in oral tradition of their early church fathers. And so I think this is a very strong document from an Evangelical Christian perspective. And so I shared that I thought it could be less than inclusive for Catholic Christians.

Q. Okay. Got it. So is that why you disagreed with -- I'm sorry. Did you say that you disagreed with the Wilson

Center's decision to become a Care Net affiliate?

A. No. No. No. No. I just said that I have some concerns with how this is written as a Catholic Christian. I think Care Net is a wonderful organization. It has -- does many wonderful things. I think it comes from a more narrow perspective. I even -- you know, before I agreed to be on the board I thought long and hard about it. I prayed about it. I talked to Dr. Christiansen who she actually had me speak to a priest who -- a Catholic priest regarding it. And so at first glance I did have some reservations, but then I felt comfortable afterwards.

Q. Got it. Thank you.

A. You're welcome.

Q. And so let's go back to the Care Net affiliation agreement.

A. Okay.

Q. Do you still have that document up?

A. I'm pretty sure it's this one right here. Statement of Faith. Yes.

Q. Okay. And so number two says the Pregnancy Center agrees to fully comply with each and every standard set forth in the Standards of Affiliation for Pregnancy Centers, attached hereto and incorporated herein by reference.

Did I read that correctly?

A. You did.

Q. Okay.

MS. SALVADOR: So I am dropping a document into the chat. Please mark it as an exhibit and then, Dr. Bane, let me know when you have it open.

- - -

(Document marked as Exhibit-EE for identification.)

- - -

THE WITNESS: I have it open.

BY MS. SALVADOR:

Q. Do you recognize this document?

A. Give me just a second.

Q. Sure.

(Pause.)

A. Okay.

Q. So do you recognize this document?

A. I do.

Q. Are these the Standards of Affiliation that are referenced in the affiliation agreement that we were discussing?

A. Yes, they are.

Q. So do the three Pregnancy Centers where you work comply with these Standards of Affiliation?

A. There was nothing I read that was a red flag to me. The one related to contraception, we don't provide

contraception at all from the standpoint of like I used to do in private practice. When we have a woman come in and she has -- let's say she wants a pregnancy test and she's not pregnant, then we have a handout for her that includes her options, as well as resources in our community for contraception. But I don't particularly prescribe contraception at the Pregnancy Center.

Q. So are -- looking at number six on the document.

A. Okay.

Q. It says the Pregnancy Center does not recommend, provide or refer single people for contraceptives. Married women and men seeking contraceptive information should be urged to seek counsel along with their spouses from their pastor and/or physician. Is that what you're referring to?

A. I was referring to the first sentence is what I was talking about. I have had discussions related to Care Net's single versus married and -- but I also recognize that as -- because we don't even do contraception there, I was comfortable signing this knowing that -- and I'll tell you, when I first started working there as a contracted doctor -- I used to volunteer, now I'm a contracted doctor -- I had to work really hard to advocate for my patients to even get a handout I developed related to contraception and being able to, you know, have the health department information on there and things like that. And they had to check with Care Net and make sure it was

in compliance. So, you know, as I said before, I love this organization, but I do push back on some things.

Q. Do you know why the Care Net standards of affiliation make a distinction between single and married had people?

A. Yeah. Because of the desire for abstinence in single people.

Q. In your opinion and experience of your medical practice, can an unmarried woman ever have a healthy sexual relationship?

MR. BOYLE: Objection.

THE WITNESS: Boy, that was a loaded question. I do think there are consequences of being sexually active for all of us, whether we're married or not. But particularly with single I do think there's literature that shows that sexual -- sexual risk avoidance, not just reduction is very effective. And so -- what I do is once again what I said earlier about that partnership between the woman and I'm not living in her lived experience, but I don't want to ever do anything that is potentially going to harm one of my patients. And so if it's a single woman who is sexually active, I'm not just going to blindly give her contraception. I'm talking to her about, you know, her risk factors for sexually transmitted infections, what is her sexual behavior, is this somebody she's been with for a long time and they have a monogamous relationship where there's a lot of trust built in. And I also know that men and

women fall hard and they hurt hard when they break up. And so, you know, I -- kind of like earlier with the multifactorial nature of studies, I know that there are many different factors related to the choice to become sexually active.

BY MS. SALVADOR:

Q. Got it. Thank you for clarifying that. Going to number one on the Standards of Affiliation document. It states that the primary mission of the pregnancy center is to share the compassion, hope, and help of Jesus Chris, both in word and deed, with those facing pregnancy decisions. The pregnancy center is equally committed to sharing the gospel of salvation through Jesus Christ with those that serve.

Did I read that correctly?

A. Yes, you did.

Q. Is that statement true for the three pregnancy centers where you work?

MR. BOYLE: Objection.

THE WITNESS: Yeah. So I believe that love is a verb and we are clearly Christian pregnancy centers. And so I believe that when you love others you're willing their good and it's -- it is doing good for people. I believe that you can meet this statement without ever mentioning the word Jesus. And you -- you can love people the way Christ loved. I think that when you look at -- in the literature with medicine when -- about 60 percent of people at least in the psychiatry

literature are in a crisis and this -- in their case it's a mental health crisis, but you can make some inferences, they want a healthcare practitioner who wants to talk about spirituality. So I will talk about that. I will sometimes pray with people if they want me to, but I -- I know they're there for a medical appointment when they're seeing me. And remember, we have two sides of the house. We have this -- the medical side of the house and so I integrate spirituality in that. But my goal -- they're in the middle of a challenge and I want to respect that they -- whatever their faith is, whether they're Christian or not, if spirituality is going to help them through that challenge, I want to encourage them in that way. The client advocacy side where they provide -- connect them with community partners and services they may need like subsidized daycare and the parenting classes, those are where I think this statement really lies and the recognition that these women are often scared and alone, sometimes being coerced, and maybe they were -- they grew up in a church and they are disconnected. And so like how could a church walk alongside them and help them. So I think, you know, yes, this is an extremely strong Evangelical statement, but it's not like we have something that says everybody must leave with a gospel pamphlet.

Q. Right. So the statement -- the Standards of Affiliation, I'm sorry, referred to sharing the gospel of

salvation through Jesus Christ. So what does that mean on the medical side as you described it as two sides?

A. Yeah. I mean, on the medical side it's really being the hands, the feet, the eyes of Jesus. Which is loving people in a way that -- like when they leave I want them to know whatever their choice is, my door is always open. And we will never judge them. And so it's in our actions. It's how we care for them, how we respect them, how we love them as we're, you know, providing information for them. And, you know, if as part of the conversation, which it doesn't happen every time, you know, some of them will say like without me even prompting them -- I mean, I have had women say everything from I'm going to hell for murdering my child, I have had them say I know God is going to be so mad at me, things like that, and I try to really meet them where they are and help them realize no, you're not murdering your child and you're trying to make the best decision at this moment that you think for yourself and I hope it can be a life-affirming decision for you. But don't own that.

Q. Are the pregnancy centers where you work subject to any form of regulation by a health agency?

A. So we -- we have -- in the State of North Carolina we have -- we actually don't have to follow HIPAA guidelines like the way my other practice did. I think that should change, to be honest. We're a medical clinic and we should follow HIPAA

guidelines and I am very strict about that. Everybody is HIPAA trained. We have medical policies and procedures that I'm in the middle of -- because I'm just starting to work with the other centers and I'm updating ours. I think our standards should be exceptional.

Q. So the pregnancy centers where you work are not inspected by any sort of state agency?

A. Not that I am aware of. I think they should be. But I don't think in North Carolina that we have that.

Q. What medical training are Pregnancy Center staff required to have -- the ones who have medical duties that is?

A. Yeah. I mean, they have to have some sort of medical license. So I have everything from nurses to medical assistants to ultrasonographers, RDMSs in the three different centers. So they have to stay licensed according to what their particular license is, their scope of practice. We do HIPAA training regularly. We do OSHA training. We do CPR training. That's all that can come to my mind right now.

Q. Thanks. That's really helpful. So going to number four on the Standards of Affiliation document.

A. Yeah.

Q. It says the pregnancy center does not perform or refer for abortion and provides a written disclaimer to this effect to clients requesting services.

Did I read that correctly?

A. You did.

Q. Is that statement true for the Pregnancy Centers where you work?

A. We don't have a written disclaimer. I have never had a patient request something like that, so I'm not sure, to be honest, what that's all about. But we do not perform or refer for induced abortions.

Q. Are the Pregnancy Centers where you work open with clients about their position on abortion?

A. So we are not -- when you say open, could you define? What do you mean by that? We're open to our clients about our position. Do we tell them? Make statements?

Q. Yeah. Do you tell them about your position on abortion?

A. Yes. So they know that we do not perform abortions. It's on our Website and the people who answer the phone who are trained to let them know that. They also know that when I counsel them and give them an informed consent I say to them my hope is you can choose a life-affirming choice for your child and yourself, but I recognize that's your decision and not mine.

Q. Thank you. And how do you split your time between the three pregnancy centers where you work?

A. Yeah. So I am in Wilson, North Carolina, about an hour east of Raleigh. And I am there actually Tuesdays,

Wednesdays, and Thursdays for about half a day each on average. And then in the Outer Banks in Nags Head I physically go there once a month, but I talk to them most days when they have a patient who's getting an ultrasound. And I'm available if they -- the ultrasonographer needs to talk to me. I just last week had -- we had a patient who was coming in and she had a 12-week intrauterine pregnancy, but the baby looked like it had some very significant skeletal abnormalities. And so as the patient was in one room the ultrasonographer reached out to me and electronically we looked at the pictures together and then I gave the staff recommendation on followup so that she could get an ultrasound and see an ob-gyn at the practice. So I'm available. None of the centers are open on weekends. They're Monday through Friday if they need consults. And then I also -- I try to read all scans within 24 hours.

Q. Got it. So for that patient you just mentioned, I just want to make sure I understand what you said. So you ended up referring that patient to an ob-gyn, is that correct?

A. I did.

Q. Okay. So you refer them out of the pregnancy center, is that right?

A. Yes. We don't do prenatal care or deliveries in terms of the -- the biggest thing that we try to do is if a woman decides to carry her pregnancy often times because of shortages in healthcare practitioners, especially in rural eastern North

Carolina, we may have some gaps so sometimes we really try to facilitate if she needs to see a maternal-fetal medicine specialist. So we do referrals. We just don't do referrals for induced abortion. As I said earlier in my testimony I have a maternal and a fetal patient and I want health and wholeness for both of them. So referral for ending the life of one of them is not a part of medicine.

Q. So understanding that you don't refer patients to pregnancy centers for induced abortions, do you ever talk to them about induced abortions?

A. Yes, I do.

Q. What types of things do you say in those conversations?

A. So I usually -- I ask their permission and if they want to talk, what information they would like and I say would you like to know about the different types of abortion. And so I may explain the difference in a medication/chemical abortion and a surgical abortion. And then I will talk to them about risks related from a medical perspective, things that we have talked about today.

Q. Have you ever received a complaint from a patient at the pregnancy centers where you work?

A. No.

Q. Has any of the centers where you work ever received a complaint related to how they handle abortion counseling?

A. Not that I -- since I have been the medical director of the three. There could have been something before that I'm unaware of.

Q. Got it. I think we're basically done here. So why don't we just take a brief break and then we'll come back. I'll ask a few more questions if I have them, which I might not, and then your counsel will have the opportunity to ask questions. So why don't we just take a -- how about a five-minute break. Does that work?

THE WITNESS: Yes. Thank you.

MS. SALVADOR: Sorry. Let's go off the record.

VIDEOTAPE TECHNICIAN: We are now going off the video record. The time is 6:29 p.m.

(A break was taken.)

VIDEOTAPE TECHNICIAN: We are now back on the video record. The time is 6:36 p.m.

BY MS. SALVADOR:

Q. Dr. Bane, are you the only ob-gyn who is employed by those three pregnancy centers where you work?

A. I am.

Q. Okay. And that's -- so that's all I have on the Pregnancy Centers. And then just going back, you mentioned that you completed a witness training through ACOG, is that right?

A. Yes, that one-day course.

Q. Did you review any materials from that training to prepare for this deposition?

A. No.

Q. Okay.

MS. SALVADOR: I don't have any further questions.

MR. BOYLE: Okay. Thank you. If it's all right, I'll go ahead.

BY MR. BOYLE:

Q. This is Ellis Boyle. I represent the legislative leaders, Speaker Moore and Senator Berger. Doctor, thank you for your time today. I have a few questions. You said in your testimony in that last hour that Mifeprex and Misoprostol are contraindicated until you exclude an intrauterine pregnancy. And I think you may have mixed up your wording a little bit and I want to give you an opportunity to clarify that if you want to. Did you mean that Mifeprex and Misoprostol are contraindicated until you would exclude an ectopic pregnancy instead of the IUP?

A. Okay. So it's Misoprostol, so I think that's what you're talking about, Mifeprex and Misoprostol. So yeah, the FDA, their prescribing information, if I said it wrong, what I meant to say is that they state that you have to exclude an ectopic pregnancy before giving the medication.

Q. Okay. Do you agree that it is safer to suspect every

patient who tests positive for pregnancy has an ectopic pregnancy until you can rule that out?

A. Yes.

Q. If you have a patient who tests positive for pregnancy and has an ultrasound that does not show either an ectopic pregnancy or an intrauterine pregnancy, so it's a pregnancy of an unknown location on that ultrasound finding, what would you say the safest way is to treat that patient?

A. I have had many patients over the years that are in that situation and I -- we do a combination of serial hCG levels, so lab work, and then a repeat ultrasound.

Q. Why would you do the repeat ultrasound?

A. To document an IUP hopefully, but also to rule out ectopic pregnancy.

Q. If you take an ultrasound of a patient who tested positive for pregnancy and it neither shows the IUP nor an ectopic pregnancy, so again, it's an ultrasound that shows a pregnancy of unknown location, does that lower or increase your suspicion that that patient has an ectopic pregnancy?

A. So it increases my suspicion because I would want, as I have said earlier, to have diagnostic certainty in something that is potentially fatal, which ectopic pregnancies can be.

Q. Doctor, if I can direct you to a couple of the exhibits that you were asked questions about. First, I believe it's Exhibit-Q. And, Madam Court Reporter, if you could tell

me if I'm correct, this would be the CDC's maternal mortality rates in the United States for 2021. I believe that's Exhibit-Q.

A. I'm going to have to find that. Just a second.

Q. Well, that's what I'm talking about, Exhibit-Q, correct?

COURT REPORTER: I don't know.

MR. BOYLE: Okay. Well, that's what I'm talking about and I think it's Q. We'll correct it after the fact, if necessary.

THE WITNESS: Is it the 2021 mortality rates?

MR. BOYLE: Yes. That's correct.

THE WITNESS: Okay.

BY MR. BOYLE:

Q. So as I understand it, when you were asked questions about these maternal mortality rates from the CDC in 2021, am I correct in saying that these are maternal mortality rates not specifically related to abortion but just for all maternal mortality in the United States?

A. Correct.

Q. Okay. And then if I can direct you to what I believe again is Exhibit-R, which would be the North Carolina 2016 maternal mortality review report. If you let me know when you get there, please.

A. Okay.

Q. Do you have that one up?

A. No. I'm sorry.

Q. Okay. Let me know.

A. Okay. Yes, I have it up.

Q. And I believe you were asked questions on page 11 of that document. Do you see page 11?

A. I'm getting there. Yes.

Q. Again, I believe you were asked questions about this page and these numbers at that chart on the bottom. And I just want to clarify again, are these numbers in that chart that represent maternal mortality in the State of North Carolina for these various years, are they specific to abortion or are they just general maternal mortality?

A. Let me look at the chart here. Overall. Pregnancy mortality ratio. So they are for all deaths, not just deaths related to abortion.

Q. Right. So all maternal death, not the specific question that you were asked later about the CDC numbers, which were the abortion-related maternal mortality, right?

A. Correct.

Q. Let me direct you to what I believe is Exhibit-S, which is the CDC mortality -- morbidity and mortality weekly report from November 2022. This is the abortion surveillance for the United States in 2020. Please let me know when you have got that up and go to page 27.

A. Actually it was still on page 27.

Q. There you go. So you were asked questions about this exhibit and it was represented that this table on page 27 for the 2013 to 2019 abortion-related maternal mortality was .43 or 43 deaths per 100,000 I believe, is that correct?

A. Yes.

Q. And this question wasn't asked, but I want you to please look at the asterisk and look at the little small print there at the bottom of this chart and tell me if I'm reading this particular part of that correctly, quote, because a substantial number of legal induced abortions occurred outside reporting areas that provided data to CDC, national CFRs, i.e. number of legal induced abortion-related deaths per 100,000 reported legal induced abortions in the United States, were calculated with denominator data from the Guttmacher Institute's national survey of abortion-providing facilities, end quote. Did I read that sentence properly?

A. Yes.

Q. And what does that sentence tell or inform your opinions in this case, please?

A. They're consistent with my opinions in my declaration that we don't have accurate information on the number of legal-induced abortions. So our -- it's difficult for us to really know the true and accurate number of complications and deaths.

Q. Okay. And does the fact that they don't have accurate data of actual abortion deaths from places that just didn't give it to the CDC and then they use the Guttmacher Institute's number as the denominator, does that impact what you think those numbers might reflect in this chart?

A. Well, I mean, I think I said earlier that your conclusions that you draw are only as accurate as the information you're drawing them from. And so I think a consistent message that I have had is that we don't do a good job because we have this voluntary reporting. And, you know, the fact that the CDC is having to rely on someone else's data is concerning. It's not surprising because if you look at the number of abortions reported between Guttmacher and the CDC, they differ vastly. So we have got to do a better job if we're going to truly understand and keep women safe.

Q. And you say the Guttmacher number is different. Isn't it much larger than the CDC number?

A. Yes, it is much larger.

Q. So if you have underreporting of the actual deaths on the voluntary information provided on that side and then you have an overinflation on the denominator from the Guttmacher, what does that tell you about your opinion about that actual number in this chart?

A. You're going to have to repeat that. Sorry.

Q. Yes. So you have underreporting of that number of

actual deaths on the top of the division, right, the numerator? Because the CDC is not getting all those deaths, is that correct?

A. Correct.

Q. And then on the bottom part, the denominator, you have got a higher number because Guttmacher has a bigger number than the CDC's reported number?

A. Right.

Q. So if you're dividing fewer on top than more on the bottom doesn't it under inflate the likely actual number -- misrepresent to the low end of the spectrum how many maternal deaths are actually attributable to an abortion in that year?

A. Yes. Your number -- your fraction would be different. It would be lower.

Q. I would like to direct you to what I believe is Exhibit-10, the Koch report from I believe the study of abortion legislation, maternal healthcare, fertility, et cetera, et cetera, in the 32 Mexican states. Can you let me know when you're at that document, please?

A. I'm there.

Q. Okay. If you turn to page 10. I believe you were asked a question about one particular sentence on page 10. Do you recall that?

A. Let me get to 10. I don't remember what sentence I was asked a question about.

Q. Okay. I believe you were asked a question about the, quote, consequently making a direct or independent causal link between a less permissive abortion law and a lower incidence of maternal deaths, or conversely by considering a more permissive abortion law would be a premature or even erroneous conclusion, end quote. Do you remember that question?

A. I do.

Q. Let me read you the next sentence and ask you your opinion of that and whether it impacts your declaration. Quote, rather, from an epidemiological perspective the Mexican natural experiment provides evidence to support three complimentary assumptions at the population level. First, abortion legislation per se did not appear to have an independent effect on overall maternal mortality rates. Second, a less permissive abortion law in terms of not considering exemptions from criminal prosecution of abortion in cases of genetic or congenital fetal anomalies was not associated with increased maternal and abortion-related deaths. And third, differences in maternal mortality incidents in the context of different abortion legislation, more or less permissive, appear to be mainly explained by the distribution of other major independent factors most likely facilitating an epidemiological transition for its low maternal mortality rates independently from abortion legislation itself, end quote.

Did I read that correctly?

A. You did.

Q. Does adding that other sentence there for context help explain why you included this report? I'm sorry, yes, this report in your declaration.

A. Yeah. I mean, it's consistent with the message that I have shared earlier about the difference between correlation and causal and the fact that we know that there are multiple factors that cause women to die and that this is -- they're acknowledging the fact that they're -- it is not one factor alone, but actually proposing that we have to look at many of the different factors. But just because you're looking at things like education and warning signs and transportation and clean sanitation and things like that, it doesn't exclude that your other observation on the trends -- you don't discount those. You just recognize the multifactorial nature of this issue.

Q. And finally, I'd like to ask you about the Fergusson study, which I believe was Exhibit-X. Again, I could be off. That's what my internal numbering was. So if we can fix that later. But you let me know, please, when you've got the Fergusson study up.

A. Okay.

Q. And go to page 450 once you get there, please.

A. All right. I can't easily find it, so I'm just going to pull up my hard copy.

Q. That's fine.

A. What page again?

Q. 450 with the implications section.

A. Okay. I'm there.

Q. Okay. Again, you weren't asked about this, so I want to give you the opportunity to explain more fulsomely why you included this study in your declaration. There's a sentence under implication that's, quote, specifically, the results do not support strong pro-life positions that claim that abortion has large and devastating effects on the mental health of women. Neither do the results support strong pro-choice positions that imply that abortion is without any mental health effects, end quote.

Do you see that?

A. Yes.

Q. And I think you were talking about that, but does that particular sentence there, and anything else that you would like to point to in this study to explain why you included this, please?

A. So I know a little bit of the back story of this study from Dr. Fergusson's -- some interviews he did because he struggled so much with getting it published and he was really disheartened that the scientific community would not publish something because they didn't like the results. And he was afraid that pro-life -- the pro-life side would use it to say

it's causal and the pro-choice side would use it to say that abortion doesn't cause mental health effects. So the next sentence is actually, I think, one of the most powerful. In general, the results lead to a middle-of-the-road position that for some women, abortion is likely to be a stressful and traumatic life event which places those exposed to it at modestly increased risk of a range of common mental health problems.

So what he's saying is that he saw an association and the scientific community has to take that association and explore it more. You know, when Tobacco was first blamed for -- and cigarettes for lung cancer, there was a whole pushback from people who wanted tobacco out there. And it took a long time for people to take that relationship seriously and he doesn't want that to happen. And he says -- I think in his study I think he says one in 10 women in New Zealand have abortions. It's one in four in our country. And why wouldn't we want to dig our feet in deeper and find out are we really helping or harming women. And that's why I think this is a critical paper.

Q. Okay.

MR. BOYLE: Doctor, I don't think I have any other questions. Thank you very much for your time. There may be some redirect or another lawyer may have a question. But thank you.

THE WITNESS: You're welcome.

VIDEOTAPE TECHNICIAN: Anyone else? All right. Before we do go off the video record I did need to see if anyone needed transcript copies, rough drafts, or video copies.

MR. BOYLE: Can I say for my side, can I just put in the chat what we want? Would that work for you?

VIDEOTAPE TECHNICIAN: It won't be on the record.

MR. BOYLE: Oh, you need it on the record? Yeah, we want a -- please, if we can for the legislative defendants, can we have an expedited by next Tuesday, if possible, and a video whenever. I imagine that's easier to do, but it does need to be synced.

VIDEOTAPE TECHNICIAN: But you don't need an expedite for the video?

MR. BOYLE: I mean, I would hope that it would come around -- if I'm paying for an expedited transcript, I'm hoping the video is coming too.

VIDEOTAPE TECHNICIAN: Okay. We'll make sure -- we'll take care of it for you.

MR. BOYLE: Okay. Thank you.

VIDEOTAPE TECHNICIAN: Certainly.

MS. SALVADOR: We would also like an expedited transcript, please. And if you have the rough ready sooner we will take that too.

VIDEOTAPE TECHNICIAN: All right. Anything else?

MS. NARASIMHAN: We would appreciate a rough, but don't need an expedited transcript. Thank you.

MR. BOYLE: Do you have contact information for where to send that, Ms. Rapaport?

VIDEOTAPE TECHNICIAN: For you, Mr. Boyle? If you could give me that in chat, that would be great.

MR. BOYLE: Sure. I'll do it right now.

VIDEOTAPE TECHNICIAN: Thank you so very much. All right. That said, today's deposition is now concluded. We are going off the video record at 6:57 p.m.

- - -

(Witness excused.)

- - -

(Deposition concluded 6:57 p.m.)

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CERTIFICATE OF REPORTER

STATE OF NORTH CAROLINA)

COUNTY OF ALAMANCE)

I, Susan A. Hurrey, RPR, the officer before whom the foregoing remote deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was duly sworn; that the testimony of said witness was taken by me to the best of my ability and thereafter reduced to typewriting under my direction; that the witness reserves the right to read and sign the transcript of the deposition prior to filing; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this deposition was taken; and further, that I am not a relative or employee of any attorney or counsel employed by the parties thereto, nor financially or otherwise interested in the outcome of the action.

This the 5th day of September, 2023.

_____

SUSAN A. HURREY, RPR

Notary Public #201826800211

I, SUSAN BANE, M.D., PhD, do hereby state under oath that I have read the above and foregoing deposition in its entirety and that the same is a full, true and correct transcript of my testimony, subject to the attached list of corrections, if any.

_____

SUSAN BANE, M.D., PhD.

STATE OF_____

COUNTY OF_____

Sworn to and subscribed before me this_____day of_____, 20_____.

_____

Notary Public

My commission expires:_____

E R R A T A S H E E T

PAGE LINE CORRECTION

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I, _____, after having read the foregoing transcript of my deposition, wish to make the above corrections.

SIGNATURE_____

DATE_____

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